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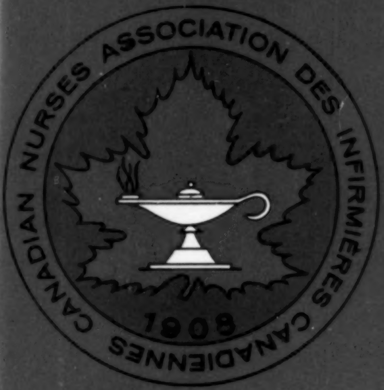
CANADIAN NURSES ASSOCIATION DES INFIRMIÈRES CANADIENNES
1908

VOLUME 57 • NUMBER 12
MONTREAL
DECEMBER, 1961

Greetings for
Christmas
and
the New Year

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THE CANADIAN NURSES' ASSOCIATION

when abnormal capillary
permeability and fragility are factors in

internal bleeding conditions

such as

menorrhagia

habitual and threatened abortion

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Between Ourselves

At this season, as for weeks past, we are besieged from every side by reminders that this is the month of Christmas excitement. The stores started their warnings many weeks ago to "do your shopping early." The post office abets those who send out stacks of cards by supplying information regarding deadline dates for mailing, in order that your messages may reach distant points in time. Groups vie with one another to arrange pre-Christmas staff parties. Invitations are already sent to chosen friends who will share the Christmas dinner with you. There is a tremendous build-up of excitement, of suspense, of good will.

In recent years, one slogan has received increasing prominence — "Put Christ back into Christmas." It seemed to us that a most appropriate way to follow that injunction would be to have the clergy of various denominations tell us about their work as chaplains in our hospitals. Because those who are ill mentally are often spoken of as being "the forgotten folk," especially at Christmastide, we included the work of the chaplain in mental as well as general hospitals.

To each of you wherever you may be, we send our Christmas greetings and good wishes. May the happiness of this season go with you into the New Year. May the peace of Christmas dispel the tensions that so often seem to threaten us.

* * *

When we were considering the content of this number several months ago, our thoughts ranged across Canada searching for a nursing leader whose message would have meaning for each of us. **Dorothy M. Percy,** our first choice, graciously accepted our invitation to be our guest editor.

Someone has written:

> It takes a certain amount of courage to lay your ideas on the line in direct, forceful prose. In doing so, you expose them for all of the world to see. You invite inspection and perhaps criticism. If you have any doubts about the validity of your ideas, there is no surer way to find out what they are worth than to house each one in a simple sentence on a sheet of paper.

As you read "Hidden among the Stuff" we are sure you will share our appreciation of Miss Percy's thinking.

* * *

Of all the countless billions of women who have borne children, through the centuries, no generation has received anything approaching the care and attention that is available today. The importance of adequate prenatal care, programs to ease the labor pains and ensure the safe delivery of healthy infants, the problems associated with various diseases in pregnant women are all developments of this century. Several of these matters are discussed in the following pages.

It is quite customary for nurses to defer to the obstetrician's point of view concerning the teaching that should accompany adequate prenatal care. A surprise awaits you, therefore, in the opinions expressed by **Dr. V. D. McLaughlin.** His theme alters the position of a few pronouns in the title of a popular song. In effect, he says "Anything I can do, you can do better!"

Abdominal decompression in the first stage of labor is one of the most recent methods of shortening the frequently long process of delivery, particularly in primiparas. Read about the success of this program at St. Mary's Hospital, Montreal.

You will get a chuckle out of the reactions of some of the student nurses to the new pattern of case room experience that has been instituted in a Saskatchewan Hospital. Those of us who received our training in obstetrical nursing many years ago may well be filled with envy.

* * *

The article "Family Centred Nursing" which appeared in the October issue of the *Journal* was written by Miss *Doreen* Weddell rather than Miss Doris Weddell.

STOP PRESS

The Executive Committee of the Canadian Nurses' Association is pleased to announce that Dr. **KASPER D. NAEGELE** has been appointed to conduct the Study of Nursing Education in Canada. Dr. Naegele is Associate Professor, Department of Anthropology and Sociology at the University of British Columbia. This Study was forecast when Recommendation 1 of the Pilot Project, "That, a re-examination and study of the whole field of nursing education be undertaken," was approved at the convention of the CNA in Halifax, June 1960.

THE CANADIAN NURSE

VOLUME 57 NUMBER 12
DECEMBER 1961

1109 HIDDEN AMONG THE STUFF .... *D. M. Percy*

Miss Percy is Chief Nursing Consultant, Department of National Health and Welfare.

1111 AN OBSTETRICAL PROBLEM SOLVED .... *K. Goos and L. Paul*

Miss Goos, formerly clinical instructor in obstetrics, is now the supervisor; and Miss Paul is clinical instructor in obstetrics at the University Hospital, Saskatoon, Sask.

1114 PRENATAL CARE .... *V. D. McLaughlin*

Dr. McLaughlin is an obstetrician and gynecologist in Moncton, N.B. He is on the attending staff of Moncton Hospital and the consulting staff of Hotel Dieu Hospital, Moncton.

1120 PREGNANCY AND DIABETES .... *G. Amyot*

Dr. Amyot, who is an obstetrician on the staff of Notre Dame Hospital, Montreal, gave this address at a conference sponsored by the Quebec Diabetic Association.

1124 PREGNANCY AND MUSCULAR DYSTROPHY .... *J. Allen*

Miss Allen, who was an intermediate student at the school of nursing, University of Alberta Hospital, Edmonton, received honorable mention for this study in the 1960 Macmillan Award competition.

1132 ABDOMINAL DECOMPRESSION DURING LABOR .... *Sr. M. Assumpta and M. Howard*

Sister Assumpta is supervisor of the obstetrical unit, and Mrs. Howard is head nurse in the delivery suite, St. Mary's Hospital, Montreal.

1139 A CHAPLAIN INTERPRETS HIS WORK .... *E. T. McKnight*

Reverend McKnight is regional representative of the Association of Mental Hospital Chaplains for the Atlantic Provinces. This paper was written in collaboration with the Rev. Kenneth M. Findley, the Rev. Donald W. Colwell, and the Rev. John R. Humphreys, chaplains of the Provincial Hospital, Lancaster, N.B.

1142 THE CATHOLIC CHAPLAIN .... *K. Barry*

Father Barry lives at St. Dunstan's Rectory, 621 Brunswick Street, Fredericton, N.B.

1144 JEWISH PATIENTS IN HOSPITAL .... *D. Spiro*

Rabbi Spiro is from Sgoolai Israel Synagogue, Fredericton, N.B.

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1145 A NEED IN OUR MENTAL HOSPITALS .... *G. McGillivray*

Father McGillivray resides at Church of the Assumption Rectory, Lancaster, N.B.

1147 CHAPLAIN IN A GENERAL HOSPITAL .... *D. V. Waldon*

Reverend Waldon is a minister of the United Church of Canada, Stanley, New Brunswick.

1150 REMOTIVATION TECHNIQUE .... *J. E. Leblanc*

Mr. Leblanc is an instructor at The Provincial Hospital, Lancaster, N.B.

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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Circulation Manager: **Winnifred MacLean**

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Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Current issue, 35 cents per copy; back issues, 50 cents per copy.
For subscribers in Canada, in combination with the
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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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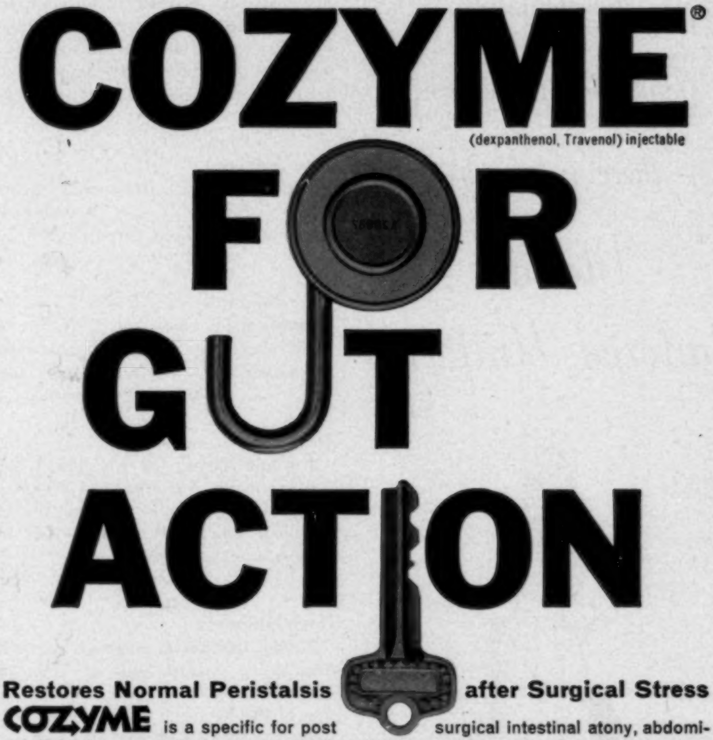

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Bibliography: 1. Lamphier, T.A.: Am. Surgeon *26*:350-354 (May) 1960. 2. Wager, H.P., and Meloah, W.D.: West. J. Surg. *67*:280-282 (Sept.-Oct.) 1959. 3. Turow, D.D.: Clin. Med. *6*:791-796 (May) 1959. 4. Frazer, J.W.; Flowe, B.H., and Anlyan W.G.: J.A.M.A. *169*:1047-1051 (March 7) 1959. 5. Stone, M.L.; Schlussel, S.; Silbermann, E., and Mersheimer, W.: Am. J. Surg. 97:191-194 (February) 1959. 6. Haycock, C.E.; Davis, W.A., and Morton, T.V.: Am. J. Surg. *97*:75-78 (January) 1959. 7. Fabi, M.: Gazz. Med. Ital. *166*:159-161 (April) 1957.

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Random Comments

Dear Editor:

On the whole, I enjoy *The Canadia Nurse* very much. But, please, could there b more articles of interest to non-practisin nurses and general duty nurses such as, nursing care studies, new bedside techniques an operative procedures, and comprehensive descriptions of some of the rarer diseases.

GAIL V. SCHULZ, Alberta

Dear Editor:

Many thanks for this month's articles o rehabilitation. It is now becoming a mos important part of our nursing care.

JOANNE OLIVER, Ontario.

Dear Editor:

I very much enjoy your excellent instructional magazine, and find it most helpful in keeping up with current nursing trends.

MARGARET J. HARTLEIB, Ontario.

Dear Editor:

I would like to tell you how I have enjoyed reading *The Canadian Nurse* during the past few months. I think the idea of including articles on related topics in each issue is an excellent one.

ELAINE MURRAY, Manitoba.

Dear Editor:

Noting the special emphasis on rehabilitation in the August issue of *The Canadian Nurse,* I wonder whether a recent publication of the Women's Bureau, Department of Labour, called *A Niche of Usefulness* has come to your attention.

A pamphlet of 53 pages, it discusses how handicapped women may learn to help themselves with the aid of vocational rehabilitation services in Canada. A chapter entitled "Careers for Women in Rehabilitation" mentions the role of the nurse and the nursing assistant in the rehabilitation team.

The pamphlet may be procured from the Queen's Printer, Ottawa 4. Price 25 cents.

MARION V. ROYCE, Director,
Women's Bureau, Department of Labour.

Dear Editor:

I would like a subscription to *The Canadian Nurse,* which I find very well done. If it is possible for a student nurse to subscribe I will be pleased to remit the cost of a subscription.

HELEN HAYES, Quebec

Dear Editor:

I have just finished reading "Burns and Pediatrics" in the September issue of our *Canadian Nurse*.

How I wish that we had had such an ideal arrangement for the treatment of burns, both adult and pediatric, when I was in training. The intensive care unit would be more enjoyable for the nurse as well as the patient. So often our burn cases were placed in a small isolated room at the far end of one of our large surgical floors, or even on a medical floor when no other room was available. It was a real effort to try and give adequate care to that patient as well as to the many other ill persons.

I hope that in the near future more hospitals will provide the kind of intensive care units mentioned in the articles.

Merle Drew, Ontario.

Dear Editor:

I would like to say that I enjoy reading *The Canadian Nurse*. The nurses with whom I work, here in Dallas, also read it and find the magazine of interest.

Betty Csaszor, Texas

Dear Editor:

Dr. Jahoda's article, "Nursing as a Profession," in the September issue, should be read by every nurse. It is gratifying to feel that we are so highly thought of by persons outside our "profession."

There are numerous books and articles discussing nursing as a profession and they certainly provide food for thought. I would like to be practical and in being so, I will probably be guilty of unprofessional behavior. Why do nurses receive such low salaries?

Several statistical tables released by the Department of National Revenue, were published in *The Financial Post,* September 16, 1961. The statistics are interesting. The average income for nurses in 1959 was $2,367, while teachers earned an average of $4,094. The average income for farmers and fishermen is just over $4,000, while dentists, lawyers, engineers and doctors were in the 11, 14, 14, and $15,000 brackets respectively. Judging by monetary values only, nurses are only half as valuable to the public as teachers. It is also interesting to note that 18.54 per cent of Canada's employed earn $3,000 or less.

Money certainly isn't everything (if it were the major consideration in choosing a vocation, the number of Canadian nurses would be even less than it is at present), but we do live in a money-minded world.

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Notice of Meeting

The President, Miss Helen Carpenter, wishes to announce that the General Meeting of the Canadian Nurses' Association will be held June 24-29, 1962 at the Queen Elizabeth Theatre, Vancouver, B.C.

M. PEARL STIVER
Executive Director

Does nursing have to be the poor church-mouse in the house of professions? In this materialistic world there is a marked tendency to judge an object's value by its cost in dollars and cents. A nursing text book valued at $2.00 would probably not be as comprehensive as one valued at $12.00. Is there not a similar tendency to gauge an individual's worth by his salary? I assume so, or else there would not be salary differentials within the profession for higher education, experience and responsible positions.

The Canadian nurse's salary is low. Provincial nurses' associations publish recommended salary scales annually. According to the world in which we live, they are based on the nurse's worth. If the profession has such a low opinion of its members our prestige in the eyes of the public will not increase. Judging by the statistics 81.46 per cent of Canada's employed are more valuable than those dedicated to the nursing profession.

As Dr. Jahoda suggests, gin is not the way to solve a problem. What is the solution?

ELAINE P. LYLE, British Columbia

¶The following excerpt appeared in the July, 1961 issue of the *MARN Nucleus*. Ed.

Early each year the Taxation Division of the National Revenue Department releases figures to the press showing the annual incomes of various groups of professional workers. Nurses' salaries usually appear at or near the bottom of the list.

It will be of interest to all registered nurses to know that these figures do not give a complete picture of the salary situation in our profession. On making enquiry, we have been advised by the Dominion Bureau of Statistics that the figures published cover all who are engaged in nursing service for a fee or who call themselves nurses. In other words, part-time nurses, "practical nurses," nursing assistants, etc. are all included. Not included are nurses employed by hospitals who, for income tax purposes, are classified as hospital employees. Thus it can be seen that the figures referred to are somewhat misleading, and that nursing salaries generally are not as depressed as they appear from the figures published.

It is an old Irish custom to place a candle in the window on Christmas Eve to light the Christ-child on his way. In Armenia myriads of candles are used in the Christmas celebrations and in Czechoslovakia tiny candles are set upright in nutshells and floated in pans of water.

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By Louise Lincoln Cady, R.N., B.S., M.A., Mental Health Nurse Consultant, Division of Mental Hygiene, Alabama State Department of Health. 489 pages, 5" x 8", illustrated, $6.50. *New (2nd) Edition!*

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By Marie V. Krause, B.S., R.N., Formerly Dietitian in charge of Nutrition Clinic and Associate Director of Education, Department of Nutrition, New York Hospital; Therapeutic Dietitian and Instructor in Dietetics Mount Sinai Hospital, Philadelphia. 716 pages, with 169 illustrations. $6.75 *New (3rd) Edition!*

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By L. Jean Bogert, Ph.D., Formerly Instructor in Department of Medicine, University of Chicago; Instructor in Experimental Medicine, Yale Medical School and Lecturer in Chemistry, Connecticut Training School for Nurses. 296 pages, illustrated. $2.50. *New (6th) Edition!*

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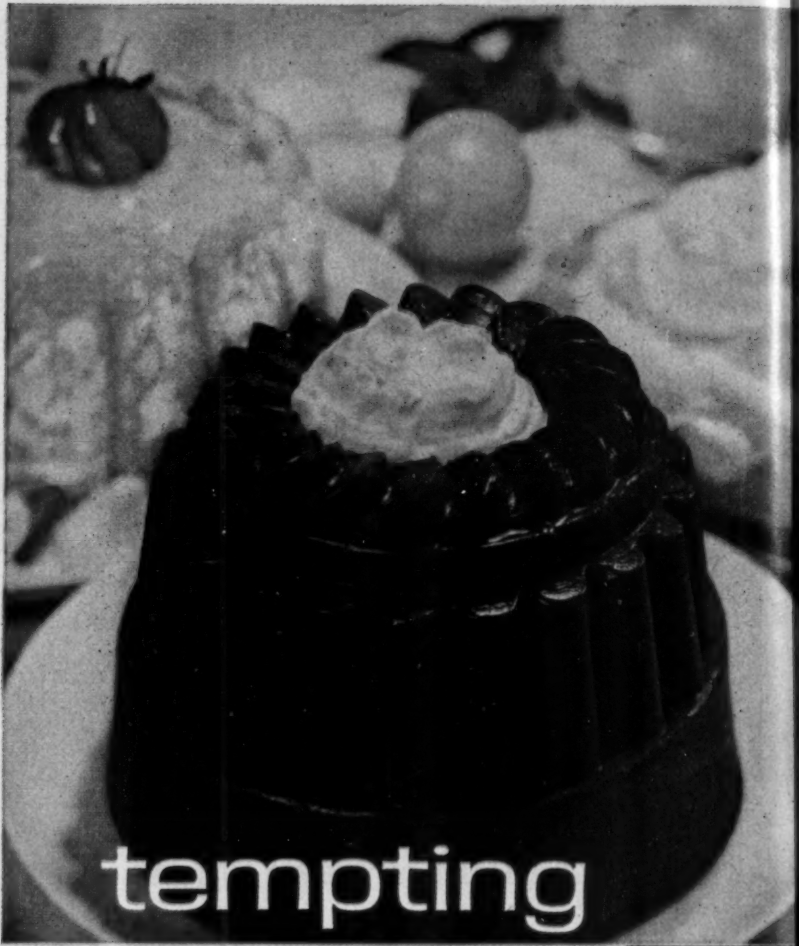

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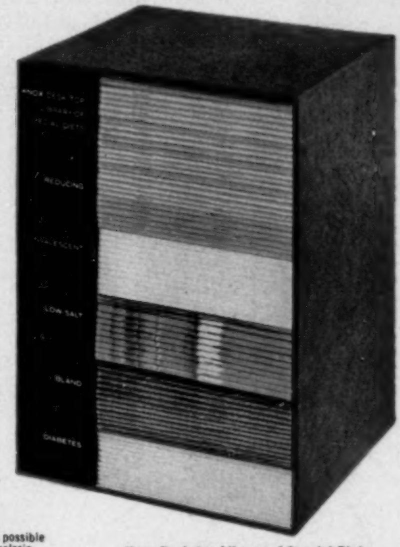
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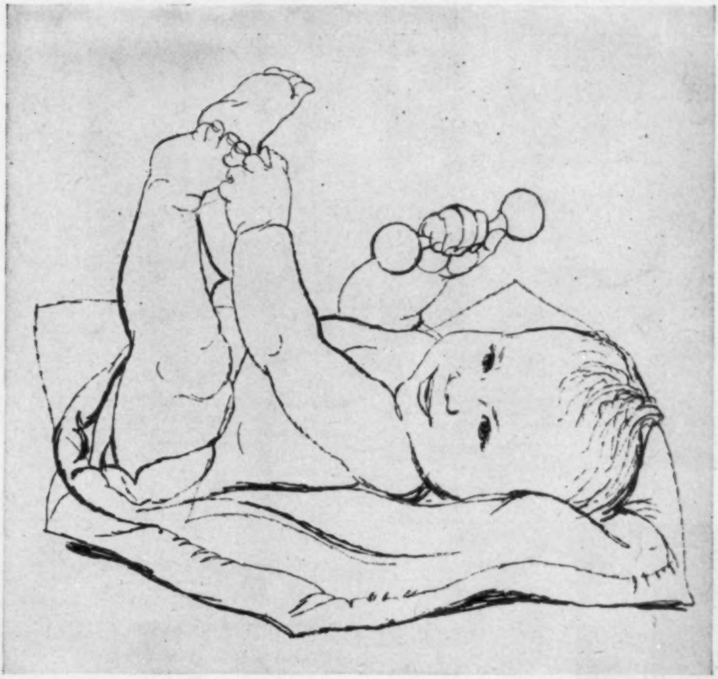

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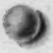

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 57 NUMBER 12

MONTREAL, DECEMBER 1961

Hidden Among the Stuff

There are times when a homely phrase from an old story seems to touch, with special relevance, on some aspect of our thinking in a moment of time. Well-loved folk tales can do this for us occasionally, also some of the stories in the Bible.

In *I Samuel 10* there is an account of the young man Saul possessed, we are told, of considerable potential for kingship but who, when called forth by the prophet to assume his high office, could not immediately be found because "he had hid himself among the stuff."

I thought of these words one hot sunny July morning this past summer as I watched the Changing of the Guard on Parliament Hill. Colorful, yes; a prime tourist attraction, certainly; but surely an anachronism in this hydrogen age, and flagrant misuse of manpower.

And yet, "hidden among the stuff" of scarlet jackets, towering bearskins, precision marching, and antiquated ceremonial would be found the intangibles of discipline, *esprit de corps,* and the pride which comes from knowledge of a job not only perfectly and beautifully done, but also carried off with an air.

Are not these some of the very things whose disappearance we deplore

(National Health & Welfare)

Dorothy Percy

today when we complain of a decline in the standard of goods and services? Quality — that sturdy, full-bodied, old-fashioned, somewhat aristocratic word — is "hidden among the stuff" of high pressure salesmanship, shoddy materials, sloppy performance, apathy, carelessness and indifference.

What about nursing? Is it possible some of its rare, precious and irreplaceable values are in danger these days of being mislaid, hidden, perchance, "among the stuff?"

What "values"? What "stuff"?

I venture to suggest several areas, chosen more or less at random where, it would seem, we should be on the alert lest this thing happen:

1. Sir William Osler was one of the first to say it was as important to know what kind of a patient had a disease as it was to know what kind of disease a patient had. In this day of rapid and breath-taking advances in medical knowledge, it is perfectly possible for the nurse to lose sight of her patient among the "stuff" of intricate equipment and complicated treatments.

2. In the area of communications and public relations *we* know (or do we?) what we mean by some of the words we use when we try to interpret nursing to doctors, administrators, patients, government, the public. What Sir Ernest Gowers in his little book *Plain Words* calls "high-sounding phrases of vague import" is a prime example of the "stuff" among which nursing can be successfully hidden. Irene Baird, dealing with the art of letter writing in a recent issue of *Professional Public Service* says: "The disconcerting thing about this pneumatic prose is how little meaning remains when the air is let out."

3. The "general practitioner" in nursing (the experienced general duty nurse) sometimes finds that her potential contribution gets hidden among various kinds of "stuff." Low salaries and lack of prestige in relation to the administrative and supervisory group; little or no voice in policies which vitally concern her; a victim, in a few isolated instances, of undemocratic, outdated, authoritarian personnel practices. It is among this group that one senses a ground-swell of discontent which the organized profession would do well to heed.

4. Examples could be multiplied of those who, for one reason or another, get themselves and their values "hidden among the stuff." There is the student nurse whose attitude changes markedly between her first and last years. She, obviously, has lost most of her enthusiasm and almost all of what (for lack of a better term) I shall call by the old-fashioned suspect phrase, "spirit of dedication." Why is she cynical, blasé, determined, she admits quite openly, to "get away from bedside nursing as far and as fast as I can?"

5. Then there is the poor head nurse, harassed and vulnerable. She finds herself responsible for the supervision of different categories of workers of whose duties, in many instances, she herself has little or no knowledge or practical experience.

If I seem to have presented an unduly pessimistic point of view, let us remember that these things of which I have spoken are not *lost*, just "hidden." Saul was found. After all, "he was higher than any of the people from his shoulders and upward." He couldn't remain hidden for very long. Neither can the heart of nursing! It is too closely identified with the basic needs of our contemporary society. Mr. Abraham Rubicoff, secretary of the United States Department of Health, Education and Welfare recently referred to nursing as the "magic ingredient in all health services."

The watchword of the International Council of Nurses for the next four years is *Inquiry*. Inquiry, in its broadest and deepest sense, can serve as the searchlight whose strong beam will penetrate the "stuff," finding again for us that which was there all the time.

At this Season we are reminded of the King who was "hidden among the stuff" of His creation. He was found by the very simple and the very wise — those in whom the spirit of inquiry was closely linked with diligence, patience, discernment, and above all with humility.

Dorothy M. Percy

Things don't turn up in this world unless somebody turns them up.

An Obstetrical Problem Solved

KATHERINE GOOS, B.SC.N. *and* LORRAINE PAUL, B.SC.N.

A successful experiment in delivery room experience for student nurses.

"HAVE YOU HEARD what they are doing at the University Hospital? The students in the delivery suite are on call for twelve hours a day for six weeks!" This is the remark that we anticipated would be buzzing around the province when we instituted a new plan of experience for students in the Obstetrical Department and a new staffing pattern in the delivery suite.

We agree with the current philosophy of obstetrical nursing that one of the needs of a patient in labor is to have emotional support provided by someone being with her throughout her labor.[1] In a hospital setting, although the husband may be present, this support can best be given by a nurse. This should, if possible, be the same nurse to provide continuity of care, and to allow the patient to gain confidence in this person. However, because of the limitations of the staffing pattern in use, we could not always provide this as we would have liked. This was poor from a teaching point of view as students would hear this philosophy stated, but only see it practised within the limitations stated above.[2] In evaluating nursing care which they gave to patients, students would remark over and over again, "I feel I could have given better nursing care to Mrs. X. had I been able to spend more time with her.

Probably one of the things most difficult to predict in an obstetrical area is the number of patients in the delivery suite at any one time. This creates many problems in trying to plan adequate experience for all students, particularly when the census is relatively small for the number of students in the area. In the past, the plan which we followed allowed for two students on evenings, two on nights, and the remainder on days with a total of 10 to 12 students in the delivery suite for a six-week period at any one time. This meant that some days there were as many as four students on duty. During this time there may have been only one patient in labor. Then, again, it would be possible that the patient: student ratio would be 5:2. As a result of the unpredictability, we were not able to take full advantage of all the experience available to the students with the staffing pattern in use.

With the aim of improving student experience and the calibre of patient care, we have substituted a "call system" in place of a regular eight-hour day in the delivery suite.

Before going on to tell you about the call system, perhaps we should give you an overall picture of the students' experience in the Obstetrical Department. It is the pattern in this school for students in specialties to have all their classes and experience concurrently. The students come to the obstetrical ward as intermediates for a twelve-week experience. They spend four weeks on the lying-in ward, two weeks in the nursery, and two observation days in the delivery suite. During this time they complete all their formal classes. The students then have six weeks in the delivery suite. It may seem a bit backward to have the student caring for postpartum patients before she has been to the delivery suite. However, we believe that in teaching students one should go from the familiar to the unfamiliar.[3] Students have previously cared for adult patients in general medical and surgical wards. This is familiar to them. By beginning their obstetrical experience on the lying-in ward, students are caring for comparatively well adult patients in a setting similar to previous ward experience. We feel this is a better learning situation than placing students immediately in the strange atmosphere of the delivery suite. By providing an observation experience in the delivery suite, the students learn what happens to patients in this area and are able to use this knowledge in caring for lying-in patients and for newborns. They, also, are less apprehensive when they begin their delivery suite experience.

How does the call system work? In the delivery suite, there is a graduate on a regular eight-hour tour of duty at all times. The students are on call from twelve midnight to twelve noon, or twelve noon to twelve midnight, five days a week with their regular two days off each week. For the sake of convenience, we refer to these call periods as being day call and night call. Each student will have three weeks of each. At the start of each call period, that is at twelve noon and at twelve midnight, the first student on call is assigned to checking the case rooms and labor rooms, and restocking as necessary so that they realize maintenance of equipment is an integral part of the smooth operation of a delivery suite. The remainder of the students remain in the residence until they are called. There is a double room in the residence which is set aside as an obstetrical call room. This room has a direct hospital extension so it is possible to telephone directly from the delivery suite to the call room. As one student is called, another replaces her in the call room. When the hospital admitting officer telephones the delivery suite to say she is bringing up a patient, the graduate calls a student. Usually, the patient and student arrive within minutes of one another. The student admits the patient, stays with her until she delivers, cares for her in the recovery room, and is responsible for her until she is transferred to the lying-in ward. Originally, we had planned for the student to scrub for the case. However, we soon found both the students and the patients requesting that the student not be separated from the patient by sterile gown and gloves. As the students put it — "the patient reaches out to us but we have to turn her away because we are scrubbed." Because of this we now call another student to scrub.

The same procedure is followed as each patient is admitted. If a patient is not in active labor, the student may go back to the residence, to be called again when labor begins. If a patient is in labor longer than twelve hours another student will be called to sit with her. We find that some days the students may work as little as one or two hours while another day they may work twelve. If, when the time comes for the student to go off call, her patient is ready to deliver the student may stay on if she wishes. Very often the students do stay. The students often go and visit a patient on the ward during her stay there following delivery.

A criticism of the call system was that the students would spend long hours in the residence with little or nothing to do. This is not the case. The students have a reading assignment to do during this last six weeks, and also, a patient care study. The reading assignment serves to broaden their knowledge in the area, and the patient care study helps to consolidate what they have learned and to organize their knowledge with reference to a specific patient. Their final examination is written at the completion of the twelve-week experience.

We find that the students demonstrate a greater sense of responsibility for their patients and, on the whole, seem much more relaxed and competent. They are able to give better nursing care to their patients in that they have become adjusted more quickly to the area, are less focused on themselves, and thus are able to "give" more. Students are better able to do critical thinking as evidenced by the nursing care they give to their patients and the patient care studies that they do as written assignments.

How do the patients like this system? They seem to be much more satisfied. We find they send back thank you notes to individual students now, as well as to the general ward staff. We interpret this as an improved general understanding of the patient on the part of the student resulting in the students being better able to meet the patients' needs. Patients frequently remark on the individualized nursing care they received in the delivery suite and on how much they learned from the student about the maternity cycle. Needless to say the doctors are pleased with the call system because their patients are so satisfied.

How does the nursing service personnel like this system? It took a bit of adjustment on everyone's part as the function of the graduate nurse in the delivery suite did change somewhat. There were many planned and spontaneous meetings that were helpful in overcoming and foreseeing problem areas. These meetings included both graduates and students. The remark heard most frequently now, after four months, is " I dont know how we ever got along the other way. Having the students on call is so much better."

How do the students like this system? Miss Sharon Bell and Miss Marion McGirr, two 1963 degree students, have volunteered to speak for their classmates:

> Twelve innocent students sat huddled in the classroom awaiting word of our rotation for the six weeks we were to spend in the delivery suite. Miss Paul, our clinical instructor, had said that there were a "few little things" she wanted to explain about it.
>
> That was the beginning. Our rotation would be an experiment, we were told, and the reasons for it were laid forth. Also, this was to be the first experiment of its kind in Canada so far as was known. We were pioneers! (Shades of Sputnik!)
>
> After the initial shock had drained, various emotions surged in to take its place. "Who do they think they are anyway? Man! Twelve hours!" "I'm glad we don't have to stay if they aren't busy." "How will I ever look after a patient in labor all by myself?"
>
> The six weeks have come and gone. Whatever else they were, they were an unforgettable experience. For instance, how could one ever forget the physical and emotional trauma of one minute peacefully dreaming of daisies at 4:00 A.M. and the next minute frantically 'prepping' a multipara with her cervix eight centimeters dilated? (After running through the rain from the residence, too!) Then, of course, there is the unique experience of coming home after scrubbing for a case, just falling asleep in your own bed (still wearing your nylons, slip, etc.) and being awakened an hour later to go down to the call room to crawl into a recently vacated, still warm bed. There is absolutely nothing on this earth to compare with the sound of a telephone (loud and clear) shattering the early morning quiet. You can't shut it off like an alarm clock, any more than you can control the panic that grips your stomach and spreads, by pathways as yet undiscovered by science, right down to your toes.
>
> In the daytime, of course, events that appear extremely bizarre to the sleep-drugged mind, somehow take on their perspective so that five deliveries in two hours is merely funny, not hilarious.
>
> On the whole, all of us (no longer so innocent about the delivery suite) have thoroughly enjoyed these last six weeks. Some comments heard at numerous gab sessions in the call room have been:
>
> 'The call system is good for fostering better patient-nurse relationships. It provides time for preparing and teaching your patient, thus aiding the mother to go through delivery with greater success and satisfactions and helping the doctor.'
>
> 'Excellent for the welfare of the patient. They really appreciate having one person deeply concerned about their comfort and progress.'
>
> 'I hate being wakened in the middle of the night.'
>
> 'It's a good thing we never get out of our uniforms. I can't get into any of my skirts. Eat dinner at midnight, coffee at 4:00 A.M., breakfast at 7:30, dinner at 12 noon, supper at 6:00. Metrecal, here I come!'
>
> 'For six weeks it was fine, but I don't think I could do it for much longer. I keep hearing telephones!'
>
> 'I like the total patient-care aspect. I like to know exactly what my patient has gone through from beginning to end. It gives you a real sense of accomplishment!'
>
> 'It was nice to have the graduate free to circulate from patient to patient and not have to leave another patient unattended when you called her. She has time to teach you so much more that way.'
>
> 'I like the way the graduates pitched in to help make the system such a success!'
>
> 'For 24 hours a day, all I can think of is work. Even in my dreams I'm always scrubbing, or 'prepping' patients, or seeing myself delivering babies. It's a sure thing I won't forget our call system.'
>
> 'You should have seen my mother's face when I told her I was a student call girl!'
>
> 'New, different, hilarious, exasperating, confusing, stimulating, and we're sure glad *it happened to us!*'

To Miss Nancy Whitehill, former supervisor in obstetrics and now Assistant Director of Nursing Service, whose original idea this was; to Miss Hazel B. Keeler, Professor and Director of the School of Nursing, who has an endless amount of faith in "her girls" and let us try this new system; and to all those graduates and students who have helped to make this venture so much more of a success than we ever anticipated, the authors say a very sincere "Thank you."

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PRENATAL CARE

VICTOR D. MCLAUGHLIN, M.D., F.R.C.S.(C)

The potential role of the nurse in prenatal care is perhaps greater than she suspects.

THE THEME of this article was intended to be prenatal care and, in particular, the answers to the questions that the obstetrician is accustomed to hearing in his office, and that the visiting nurse is likely to be asked when she visits the prenatal patient in her home. This seemed a simple matter at first. Apparently all that was necessary was a record of the questions asked over a period of time and the variable answers given. Unfortunately, I began to think about how the nurse would answer these questions in the patient's home; how she would use the information derived from seeing the patient's environment. As a result, it became very obvious how much better the nurse could do this part of the doctor's job than he could. A very humiliating experience!

Introducing Alice

Alice is a young woman in her late twenties, relatively good-looking, whom I first saw early in her fourth pregnancy. On the several occasions when she was in my office she was always well-groomed, attractively made up, neatly and fashionably dressed. As time went by and Alice moved into maternity clothes, these too were attractive, neat and distinctive.

Alice was always very pleasant. She asked sensible questions and was able to carry on the usual type of casual conversation. My impressions about her were: that she was an attractive, reasonably well-to-do young woman of average intelligence, with a fairly sensible attitude toward life but slightly inclined towards the frivolous side. Then one evening I was called to Alice's home. She was complaining of nausea and right lower quadrant pain. Her history did not include the reassuring note of a previous appendectomy.

At approximately 8:30 P.M. I went to her home and discovered that Alice lived in an apartment which I would classify as three rooms — a small kitchen, a living room, a bedroom for her two sons and another bedroom in which she and her husband slept, and which contained a crib for the youngest child. The youngest child was in bed. The other two were sitting in front of the television set without any evidence of preparation for bed, in spite of the fact that they were approximately four and six years of age. The father came to the door and showed me to the bedroom where Alice was. Then he promptly returned to the television set. The supper dishes were still unwashed. I am sure that her husband was much more concerned with the peril of the "good guy" who was about to be ambushed than he was about the pain that Alice was having in her abdomen. I squeezed through between the dresser and the foot of the bed, examined Alice, ascertained that she probably did not have acute appendicitis, but was having moderately severe abdominal pain, gave her an injection and left.

My estimation of Alice changed remarkably in the space of that 20 minutes. It was now quite obvious that she was the bulwark of the family; that she looked after the children without any assistance whatever; that she kept herself neat and well-groomed under obvious difficulties; and kept up a family appearance almost single-handedly. Anyone could see this at a glance.

Now you can see why you, in her home, could answer her questions and her problems much better than I. In other words, you could do my job better than I can. In my case, Alice is the exception. It is only occasionally that I get the opportunity to see the patient's home.

Prescribing Exercise

From time-to-time, young women come to the office who have rural addresses, and who say that their husbands are farmers. But that does not give a great deal of information. One wife who says that her husband is a farmer may mean that he keeps 10,000 chickens and has nine men working for him; that she has every convenience that any of you have in your homes. Another one might not be so fortunate. When the nurse visits in the home she can tell the difference at a glance. To one woman, the doctor's advice that she should get outdoor exercise daily is very sound. To another, it is simply ridiculous. You, in the home, would not likely advise regular outdoor exercise to the woman who goes out every day to milk the cow, feed the chickens, carry water, and use the plumbing facilities that do not happen to be indoors!

Prenatal Records

What does the doctor routinely do for the patient during pregnancy, and why? On all my prenatal records there is a list in the right hand margin with some 14 items in it. These are crossed off as they are taken care of.

The first is the *history*. It is emphasizing the obvious to say that the most important aspect of the obstetrician's care of the patient is taking a thorough history but even as I say this, I condemn myself for my own inadequacies. Yes, the doctor takes a history of where the patient lives; how old she is; how many babies she has had; whether they were normal deliveries; how long she was in labor; whether the babies were boys or girls; whether or not they were normal, healthy; whether or not she had any postpartum complications. He includes a history of previous operations or previous illnesses, and those specific diseases that leave behind scars which impair the health and may affect childbearing; rheumatic fever, diphtheria, pneumonia, tuberculosis, venereal disease, and renal diseases. He takes a history of the family background, specifically of the health of the parents and siblings, causes of death as necessary, and a history of those diseases that show a definite familial tendency, especially diabetes, hypertension, epilepsy, and allergy, all of which involve decided heredity factors, and tuberculosis which, although not hereditary, is a disease of contact.

But, and this is a very big BUT! Nothing in this history tells anything of the patient's family situation, her specific problems, her worries and her anxieties. A certain amount can be surmised. For instance, from the fact that she has been married for seven years and has six children already, this is a pregnancy that was unplanned, and very likely unwanted. It is very difficult for a doctor in private practice to inquire into a patient's financial situation and problems. It is always interpreted as concern over whether or not he is going to get paid. People usually lose sight of the fact that the patient's health may be directly or indirectly affected by finances. As a result, this area is also left to surmise and supposition that is all too often incorrect.

Stop for a moment now. Think how much of the patient's history could be filled in by walking into her home, especially if you go by way of the back door past the garbage can!

The next item on the list is *general physical examination*. When I thought about this item I began to feel better. This seemed to be something that I could do which the nurse could not. Here was some justification for my being! But — is this true? When the nurse goes into the patient's home and finds her coughing, wheezing or short of breath as she does her housework or the family washing, does she say to herself, respiratory infection, asthma, rheumatic heart disease? Maybe not, but she does note that this is a patient who is obviously not in good health. When that same patient comes to the doctor's office, unless she happens to be the first in line, she sits in the waiting room for half an hour before she comes into the consulting room. She appears rested, with no evidence of respiratory disease and her asthmatic condition goes unnoticed. Or the doctor does not hear the heart murmur and misses the rheumatic heart disease.

Again the nurse may see the mother when she is doing the washing over a basin that was installed 25 years ago and is about four inches lower than it should be. There she stands, bent over that sink for hours, washing diapers, bibs and father's shirts. When she comes to the doctor's office, he makes sure that she is seated on a firm, straight-backed chair. She says that she has a backache. Which one of us, the doctor or the nurse, is more likely to recognize the cause? The same situation applies to her varicose veins, the contact dermatitis on her hands, and a dozen other matters. Am I *really* more capable of a good physical examination than you are?

The third point on the list is *pelvic examination*. Here, at last, is my forte. Here, at last, we have entered the *sanctum sanctorum* where the obstetrician, and the obstetrician alone, will care for the patient — but is this true? There are obstetricians who believe quite honestly that a patient can be well cared for without a pelvic examination ever being carried out. As for the other incidental problems that arise such as cervicitis, vaginitis and minor episodes of vaginal bleeding, I might have thought once that the obstetrician would hear about these problems first, but after hearing about the many, varied, and personal problems that patients have already discussed with not one, but 19 neighbors I can only say that you, as women going into the home, are very, very likely to hear about them long before I will.

On the first or second visit, the patient is initiated into the habit of bringing a urine specimen with her on every visit to the office. There are two reasons for this, diabetes and pre-eclampsia. *A patient who has sugar in her urine at any time during her pregnancy is diabetic until established otherwise.* It is true that a few patients will spill sugar into their urine while their blood sugar remains normal and who, in fact, do not have diabetes, and do not subsequently develop it. The problem of the pregnant diabetic patient is becoming increasingly important, since more and more diabetics are having children.

The other reason for urine analysis is, of course, in relation to eclampsia, this is the greatest single contribution that the obstetrician makes in prenatal care. Pre-eclampsia, or toxemia of pregnancy, is an insidious disease that causes symptoms only after it has reached the serious stage, one that is well beyond the point at which treatment should be instituted. The regular and systematic examination of the patient for the early evidence of pre-eclampsia is the most important single aspect of prenatal care. This you can explain to the patient as well as I. In fact, for *me* to tell the patient that it is important to come in regularly to have her blood pressure, weight, and urine checked, is *advertising!* For *you* to say it, is gospel! After all, you have nothing to gain by it!

This, of course, brings us to another aspect of the prevention and early detection of toxemia — the regular observation of *weight*, and what the ideal weight change of pregnancy should be. Ideally, weight change in pregnancy is a controlled gain. It should be between 17 and 20 pounds. Rarely, should it exceed 20 pounds. It should be a gradual, relatively constant rate of gain. The inherent weight gain of pregnancy, that is, the weight of the baby, of the placenta, of the amniotic fluid, of the uterus, of the breast, and the increase in the mother's blood volume, adds up to approximately 17 pounds. This leaves an additional three pounds or so for the mother to gain in fat. There are usually 40 weeks in a pregnancy. Twenty pounds in 40 weeks means exactly half a pound per week. Twenty is a lovely figure!

Speaking of figures, it is always well

to point out to the mother that if she keeps her weight gain at 20 pounds or slightly under she will be storing little fat and therefore she will not alter her figure appreciably during her pregnancy. You can talk about toxemia for hours and it will not make half the impression upon the patient that the words "your figure" will make in a minute. Vanity, vanity, thy name is woman! It's a fact! When you deal with the prenatal patient make use of it.

To make sure that the patient has an adequate intake of *vitamins, calcium,* and *iron* during her pregnancy can be tedious, expensive, and unsatisfactory. Vitamins, by their nature, necessitate a supply of fresh fruits and vegetables. This is easy at times and at others it is difficult and expensive. Calcium is readily available in foods. The patient can get it in milk, but *whole* milk is a fattening food. To the patient who has difficulty with weight control a quart of milk a day may present a problem.

Iron intake is a real problem for all mothers, however. The normal menstruating young woman just barely keeps herself in iron balance. What she takes in during a month in her ordinary diet is just equal to what she loses in her menstrual flow. Pregnancy presents her with a demand for iron approximately tenfold that of menstruation, that is, ten times what she would lose during menstruation for *ten* months, not just *one* month. Therefore, every woman should have an increased intake of iron during pregnancy. To do this through diet alone is difficult. Most patients can afford one of the less expensive multivitamin and mineral preparations.

The other very important element of diet is *protein.* Protein is a must for the mother and the baby. There is good evidence to show that some of the complications of pregnancy are more common in women on a protein-deficient diet. Protein foods should always be emphasized. Unfortunately they are often expensive since they include meat, fish, eggs and cheese.

Next on the list is *hemaglobin* estimation. There is no need to elaborate. It is purely and simply a test for anemia. Not only is there danger in the anemia itself, but it predisposes to many of the complications of pregnancy and delivery.

A blood Wassermann or some form of serological test for syphilis is a necessity. Syphilis still exists; there are innocent victims of it; it is a potential killer of babies. There is no excuse for an infant's death as a result of syphilis. Every pregnant woman with a positive Wassermann must be treated and every woman should have a Wassermann done early in pregnancy.

Perhaps no other advance in relation to the problem of perinatal mortality has been as gratifying as the discoveries concerning *erythroblastosis* made in the last 15 years. It has practically all been done by the pediatricians. In 1942, the Rh factor was just coming to light. Since then it has been divided and subdivided. More and more has been learned. The point has been reached where, by taking periodic blood specimens from the woman who is Rh-negative, it can be predicted with reasonable accuracy which babies will be affected, which ones will need exchange transfusions; which ones are likely to be stillborn if carried to full term. Fortunately, this prognostic accuracy has been matched by the ability to treat these babies. We can avoid most of the deaths and crippling sequelae that previously followed this condition. Within the past five or six years the possibilities of ABO incompatibilities have come to light. That is, mothers who are group O and whose husbands are group A or, rarely, group B. For these mothers it is now important to know the husbands' groups as well, in order to facilitate early detection of the problem. It should be sufficient to tell your patients that, if they are Rh-negative, they should have periodic blood examinations done. You can also reassure them that they are now very unlikely to lose babies as a result of this missing factor.

Radiography

It may be safely presumed that nurses, like their patients, regularly read the current medical literature in the *Ladies Home Journal* and the *Saturday Evening Post.* Therefore, you will know that there is much controversy on the subject of whether or not women should be exposed to x-rays during pregnancy. True, before ordering radiographic pelvimetry, intravenous pyelogram or similar x-ray procedures to which the pelvis with the fetus would be exposed, there should be serious second thoughts. However, it seems unnecessary to worry over one chest film, especially if it happens to be the low-dosage screening film. The facts remain that early tuberculosis can be detected *only* by x-ray; that tuberculosis may advance rapidly in pregnancy; that while tuberculosis during pregnancy is no longer considered with the alarm of 25 years ago, the woman with active tuberculosis should be in bed throughout her pregnancy.

Advice

Exercise takes into account the general measure of outdoor walking daily if possible but, in addition to that, it refers to specific exercises that I recommend for all pregnant women. They are aimed at the maintenance of good muscle tone in the back muscles and in the abdominal wall. They consist of back arching, straight leg raising, and sitting up from the lying position. They are simple to explain, simple to understand. They are aimed simply at counteracting that which is done by pregnancy in terms of the protruding uterus stretching the abdominal wall and causing the mother to bend backwards when she tries to stand up straight.

Breast feeding is included to ensure that the subject is discussed with every patient. Essentially, women fall into three categories as far as breast feeding is concerned. There are those who want to nurse their babies. They require encouragement and a reminder of the fact that they will hear many pseudo-reasons for not doing so. They must remember that most women *can* nurse their babies *if they want to.* Then there are the mothers who do not want to nurse their babies and say so frankly. In some cases they have been persuaded to do so. The experiment usually lasts about 10 days. They nurse their babies while they are in hospital but discontinue it as soon as they return home and come under the influences that originally persuaded them against it. This makes unnecessary problems for everyone concerned, including the baby. Finally there are the mothers who "sit on the fence." Basically, they want to nurse their babies but they have heard so much about the difficulties involved, the possible problems, the doubts of others concerning their ability to nurse, that they do not know what to do. They should be encouraged to breast feed if they wish to do so, reassured of their ability but reminded that they must make up their minds definitely so that they will undertake nursing resolutely — otherwise they will probably fail.

The last item — *labor* — reminds me to spend a few minutes discussing this subject, especially with the women who are having their first babies. It is a sad reflection that, for all too many of them, this is their only knowledge of what is about to happen to them. The way in which labor contractions begin and some of the variations, the spontaneous rupture of membranes, and the appearance of bloody show are all explained. The mother is reassured concerning the normal nature of the latter two signs. In addition, the patients are asked to call the doctor when they believe that they are ready to go into hospital. It is amazing how much information can be obtained simply by a telephone chat with the patient. Occasionally, the mother who is in false labor can be saved an unnecessary trip to hospital.

Questions

There are a number of questions that the mothers ask frequently but certain ones predominate. They are: Will I be given anything to relieve my pain? Do you use anesthetics? These queries are linked to another one: What do you think of natural childbirth?

The common attitude nowadays seems to be that analgesia and anesthesia are incompatible with natural childbirth. Natural childbirth is based, simply, on the well-known principle that fear is a cause of pain and the alleviation of fear will, in turn, alleviate pain. There is nothing in this concept that is incompatible with the relief of pain by analgesic drugs.

May I have dentistry done during pregnancy? This is a question that should be anticipated by recommending to all patients during their initial examination that they should have their teeth checked unless this has been done within the past six months. It is preferable for a patient to have multiple extractions in the early or middle stages of her pregnancy than for her to have an apical abscess during the last two months.

There is always an exception that proves the rule. Some time ago I saw a patient in early pregnancy who had chronic hypertension with a constant blood pressure of approximately 140/90. She had very poor teeth and I advised her to have them cared for *immediately.* This advice was repeated on subsequent visits since she had not attended to the matter. In her eighth month she came into the office looking very pleased with herself and announced that all of her decayed teeth had been removed. I took her blood pressure 180/110!

What can I do about my varicose veins? Wear elastic stockings! The fact that some individuals were probably born with fewer valves in their veins than others can not be changed. However, the patient can be helped to reduce the number of valves that are destroyed by the pressure of a pregnancy. Support the veins in order to protect them from further damage. Avoid recommending elastic stockings on the basis of their present comfort! Many patients say that the heat and the itching is worse than the soreness of varicose veins.

Do I need a maternity girdle? If the mother's back is bothering her and she feels more comfortable when the protruding uterus is supported, then she should wear a maternity girdle. However, she should not rely upon it entirely but should do back exercises as a primary measure of relief. Personally, I do not feel that maternity girdles offer much protection for the back but they do provide comfort in some cases. The latter is the main justification for their use.

May I take tub baths? The danger in tub baths is the tub itself. A woman in late pregnancy is awkward and may easily slip and fall. Even standing in the tub for a shower can be dangerous. As far as the bath itself is concerned, my opinion is that the mother can take shallow tub baths up to and including the time that she goes into labor.

Will paint fumes hurt my baby? I have tried unsuccessfully to find out where this idea originated. So far as *anyone* knows, paint fumes will not harm the baby *in utero.* The only fumes that can kill the baby without killing the mother are carbon monoxide.

Finally, "Doctor, I have only one tube (ovary). Is it true that I can have only boys (or girls)?" If it were true that the left or right ovary was the "boy" tube or "girl" tube, I would not be answering this question. I would be advertising it! I am sure that there would be a standing line of mothers willing to undergo surgery quite happily in order to ensure the sex of the next baby ! !

Postnatal Care

This is the area in which the great deficiency today can be corrected by the nurses who go into the home of the mother with a new child. If any single visit to the obstetrician's office is more important than any other it is the visit after the baby is born. For some of the patients, nothing is required except to verify that all has returned to normal. For others, continued iron therapy for anemia, correction of sleeping habits, advice about further pregnancies may be required. The most important aspect is to *make sure that the cervix is healthy before the care of the pregnancy is considered over.* Many, many women after delivery have a chronic cervicitis. This gives rise to a persistent discharge and chronic irritation of the cervix. Here are some statistics from Novak's *Text Book of Gynecologic Pathology.* In one series of 18,000 women with adequate treatment of irritating lesions of the cervix, only 15 subsequently developped carcinoma. In another series of 2,200 *with carcinoma* of the cervix only 33 had had adequate care of lesions of the cervix previously. These figures are not conclusive, but they are very suggestive. In this present day in which our treatment of carcinoma of the cervix, is very frequently inadequate it behooves us to do anything that can possibly prevent the disease. Examination of the patient after delivery is a far more direct approach than the periodic routine examinations that are so widely advocated. Unfortunately, there are still too many postnatal patients who do not return to their doctors. The nurse who sees the mother in the home six to eight weeks after delivery can be much more concrete and definite than I can. Once again, *you* can do my job better than *I*.

Conclusion

Of all that the doctor does routinely pre- and postnatally, there is much that the nurse can do almost as well. She sees the patient in her own home; knows the circumstances under which the mother must care for herself; appreciates how much must be done for the household generally; has an idea of the financial circumstances of the family and any conflicts that may be present. The doctor in his office has little or no opportunity to obtain such information. Simply because the nurse is a woman and "understands how men are," the mother confides in her with greater readiness. Thus the nurse is better equipped than the doctor by reason of knowledge and femininity to carry out aspects of prenatal care.

Pregnancy and Diabetes

GILLES AMYOT, M.D.

Modern medical technology has made motherhood possible and relatively safe for the diabetic woman.

PREGNANCY IN THE diabetic woman requires serious consideration. To illustrate this point it is worthwhile to remember that, before the discovery of insulin, the majority of diabetic women were unable to conceive and bear children. As a matter of fact, 50 per cent of diabetic females did not menstruate. This sterility was apparently the result of general endocrine imbalance both from a lack of insulin and a deficiency of the nutritive elements necessary to proper function of the reproductive organs. The latter was due to the severe dietary restrictions imposed on the diabetic patient.

Cessation of menstruation indicated the absence of a menstrual cycle and, consequently, the absence of ovulation. Pregnancy was obviously an impossibility. Under the circumstances, this was a fortunate state of affairs since the pregnant diabetic woman faced grave risks. Maternal mortality in diabetics was about one in four pregnancies or 25 per cent. In most instances death resulted from acidosis and diabetic coma. Since that time various factors have reduced the death rate in diabetic mothers almost to zero. The discovery of insulin and antibiotics; the existence of blood banks with their facilities for emergency transfusion; improved organization of hospital obstetrical services, and so forth, have reduced diabetic maternal mortality from 25 per cent in 1921 to less than one per cent in 1958. Considering that the deaths which still occur are partly due to negligence, this figure could be further reduced to almost nothing. The conclusion that can be drawn from all of this is that the pregnant diabetic woman must have very close medical supervision. Without it, she encounters the same dangers as the diabetic mother of pre-insulin days.

Prior to the discovery of insulin, the fetal mortality rate was approximately 50 per cent. Although it has been rduced considerably since that time, it is still high — 15 to 20 per cent. The reasons for this will be noted later.

The Effect of Pregnancy

It is obvious that pregnancy for the diabetic woman is neither of little importance nor commonplace. It constitutes a serious problem. The mother must appreciate the necessity for close supervision in order to avoid disastrous results for herself or her baby.

How does pregnancy affect the diabetic woman? Her diabetic condition tends to become a great deal more difficult to control. Will she need more or less insulin? This varies widely from one patient to another, particularly in relation to the stage of pregnancy. As a general rule most diabetic mothers will require a greater quantity of insulin during the first six months while their requirements will be less during the last trimester. However, this rule is obviously open to exceptions.

While it is true that pregnancy is an absolutely normal, physiological process, and that its existence in the diabetic woman simply *proves* that she is normal, nevertheless it produces physiological disturbances. Almost all organs in the body undergo some change. These changes are exhibited in various ways and help to explain some of the symptoms seen so frequently during pregnancy; drowsiness; general malaise as a result of a slower digestive process; distention; "heart burn"; constipation; urinary frequency. These phenomena are so common that women who have had several children may remark that they never feel better than when they are *not* pregnant. Equally significant is the fact that when the fetus dies *in utero,* the mother will often say, "I don't *feel* pregnant," this, in spite of the fact that the fetus has not yet been expelled.

The Role of the Placenta

What causes these physiological changes? To a large extent, they result from the influence of the placenta which has several roles to play. Its principal function is undoubtedly to assure the respiratory and nutritive exchanges between the mother and baby necessary to the latter's development in the uterus. At the same time the placenta can be regarded as an important gland. It secretes several hormones in large quantities. During the first six months of gestation there is an increased quantity of corticosteroids, substances similar to cortisone. It is felt that this increased hormonal content comes both from the placenta and the adrenal gland.

It is known that cortisone increases the blood sugar which explains why, in most instances, a greater quantity of insulin will be necessary during the first six months of pregnancy in order to maintain a normal blood sugar level. During the last trimester it is thought that the fetal pancreas begins to function and that it secretes insulin which passes into the general maternal circulation thus reducing insulin requirements in the mother. Again, this rule is subject to individual variations.

Will pregnancy aggravate the diabetic condition? Generally speaking, this will not be the case. However, it should be noted, that if the diabetic woman is already presenting renal or vascular complications prior to conception, then her pregnancy will aggravate these complications.

One factor merits special mention. Frequently diabetic patients will show sugar in the urine even when the blood sugar is normal. This is known as a lowered renal threshold. Consequently there should be no cause for undue alarm if glycosuria appears more frequently during pregnancy than before.

The Course of Pregnancy

How will the course of pregnancy be affected by the diabetic condition? Are diabetic patients more prone to miscarriage than others?

About 10 per cent of women in the general population have their pregnancies terminate in miscarriage. What is the significance of this? In most instances, the cause of miscarriage is unknown. The exception is when the woman has a uterine abnormality or a hormonal insufficiency. In the diabetic woman, the incidence of miscarriage may be slightly higher — about 12-15 per cent. This is of such minor significance that, for all practical purposes, it can be said that diabetic women have no more miscarriages than nondiabetics.

The nausea and vomiting of early pregnancy is not encountered with any greater frequency or severity in the diabetic mother. However, if vomiting persisted, there might be difficulty in controlling the diabetes and acidosis might occur.

Complications of Pregnancy

There are certain complications of pregnancy that tend to occur more frequently in diabetic than in nondiabetic patients, particularly if the diabetes is not well-controlled. Of these complications, the toxemias of pregnancy belong at the top of the list. The most serious and most important manifestation is eclampsia. Its incidence is distinctly greater in diabetics. In this instance, we are dealing with a condition, in which we are ignorant of the exact cause. It is characterized by hypertension and edema of the hands and face in particular. The patient also exhibits albuminuria. If she is not treated, the end result may be convulsions, coma and death. In almost 90 per cent of cases, there is a characteristic gain in weight. For this reason obstetricians are especially strict concerning their patients' diets. Control over weight gain reduces the toxemias of pregnancy remarkably.

Normally the pregnant woman should gain 20-25 pounds. Generally speaking increased appetite accompanies pregnancy. If uncontrolled, certain patients could gain 50-80 pounds with a resulting increase in the incidence of toxemia. Following her diet carefully is important to both the diabetic and non-diabetic mother, but it has special significance for the former. Greater control over her diabetic condition means a decreased incidence of toxemia.

Hydramnios is another condition that is found more frequently in the pregnant diabetic. The fetus is bathed in amniotic fluid within the uterine cavity. This cushion of fluid protects the baby against external shocks; permits movement by the child; facilitates passage through the birth canal during labor. If the quantity of fluid becomes abnormally great, the condition is known as hydramnios. Its severity varies according to the stage of pregnancy and the amount of fluid present. Unfortunately, this condition occurs fairly frequently and, even with the best means at our disposal, it can not be anticipated. It is dangerous and harmful to the baby. When hydramnios develops at seven and one-half to eight months, it is sufficient indication for induction of labor in the diabetic patient.

Diabetic mothers tend to have abnormally large babies. This is such a common occurrence that when an apparently normal woman gives birth to a very large baby, she is checked for diabetes herself and for a family history of it. It is interesting to note that the excessive weight of the baby has no bearing on the severity of the mother's diabetic condition. Indeed, certain women who are only in the *prediabetic* state give birth to huge babies. These large babies cause difficulty during labor and delivery. Consequently, forceps delivery is used more frequently.

Is Caesarean section required more often in diabetics than non-diabetics? The answer is affirmative and there are two reasons for it. The first is that, in the majority of cases, labor must be induced about the eight month of pregnancy. However, especially when the mother is a primipara, labor may be almost impossible to induce. The patient must have a Caesarean section. The second reason is, of course, the abnormally large size of the child. The disproportions in the size of the baby and the dimensions of the mother's pelvis and birth canal are simply too great. Before subjecting a patient to Caesarean section other factors such as the type of presentation, the extent of engagement within the birth canal, and the quality of the uterine contractions must be considered.

The Diabetic Mother's Attitude

What should the diabetic woman's attitude toward pregnancy be? She should be optimistic and confident, remembering that her prognosis is good; that eight out of ten babies born to diabetic mothers are produced normally and are normal. The patient should warn the specialist or the physician who is treating her for diabetes of her possible pregnancy. This should be done as soon as the earliest symptoms appear. The doctor can confirm the pregnancy and refer his patient to an obstetrician. This introduces an important principle. *The diabetic mother must continue under the care of both the physician and the obstetrician.* When an important decision, such as the induction of labor, must be made the two doctors must consent together and achieve common agreement.

In a number of instances it may be necessary to hospitalize a pregnant diabetic patient at least once during the course of gestation in order to assess her condition generally and to control her diabetes more effectively.

Finally, the diabetic mother should

be aware of the fact that labor may be induced before she reaches full-term. It has been proven quite definitely that the best results are obtained when labor is brought on about four weeks in advance of the expected date of confinement. This is particularly true in relation to the baby's survival.

Induction of Labor

There are certain preconceived ideas concerning induction of labor that should be dispelled. Questions frequently asked: "Is it dangerous, either for the mother or the baby, to induce labor? Are the uterine contractions more prolonged and stronger when labor is induced prematurely?"

If the obstetrician is competent and if he uses efficient, safe methods of induction, then induced labor is not dangerous. The proof that it is not lies in the fact that it is being used more frequently in the care of diabetic obstetrical patients to ensure a greater number of normal babies in good condition at birth. From available evidence, it would appear that babies have survived who might otherwise have been seriously affected by full-term pregnancy.

The pain of uterine contraction is definitely not greater as a result of induced labor. The duration of labor and labor pains are subject to a great many individual variations. Induction of labor does nothing more than institute the process. Once begun, it develops in the same way that it would at the end of a full-term pregnancy. It might even be said that induced labor is *less* prolonged since the baby's weight has some relation to it. At full-term, the baby would be correspondingly larger and labor more difficult.

What to Tell the Doctor

There are certain special symptoms that the mother should report to her doctor immediately since they may be indicative of serious illness. These are:

1. Any vaginal bleeding, regardless of apparent harmlessness.
2. Any marked abdominal pain.
3. Any drainage of amniotic fluid per vagina.
4. Shivering and fever.
5. Excessive vomiting.
6. Persistent headache.
7. Edema of the face and fingers.

These symptoms, in some instances, may have no significance. In others, they may be warning signs of a complication that can be easily averted through early treatment.

Questions and Answers

The question of exercise often comes to the fore as well. Should the pregnant woman exercise? What form should it take? Pregnancy is a normal, physiological condition. However, the pregnant woman tires more readily. Consequently, while exercise is permitted and encouraged, it is only beneficial to the degree that it produces relaxation and a healthy fatigue. Certain sports and occupations are, therefore, contraindicated.

Should the pregnant woman have an outside job? As long as the work does not produce excessive physical or mental fatigue, this is permissible. When should she stop work? In general, six weeks to two months before the expected date of confinement is a reasonable length of time.

Is travelling allowed? Not too long ago, the pregnant woman was forbidden travel of any kind. Today such restrictions are rare, regardless of the distance or means of transport. Once more over-fatigue must be avoided. The method of travel is a deciding factor. However, during the last two weeks of pregnancy it can be stated without fear of contradiction that extensive travel is contraindicated.

Conclusion

1. Since the discovery of insulin, diabetic women have a greater degree of fertility.
2. Pregnancy in the diabetic woman should be regarded optimistically.
3. Pregnancy will not aggravate the diabetic condition but the diabetic patient has a greater tendency towards obstetrical complications.
4. The key to success lies in effective control of the diabetic condition and early detection of obstetrical complications.

Health — an eager mind in a live body. — Tait Mackenzie

Pregnancy and Muscular Dystrophy

JUDITH ALLEN

For the normal, healthy mother the birth of her baby is an exciting event. With proper medical supervision, the handicapped mother can look forward to having her baby with equal delight.

Social History

Mrs. Bryan and her husband, were both raised in a small town south of the provincial capital where they eventually received their education. Mr. Bryan came from a Norwegian background and his wife was a Canadian. Both families had been anxious for their children to gain a higher education and Mr. Bryan had received his Bachelor of Education while his wife-to-be took a course in photography. She worked as an assistant to a photographer until Mr. Bryan had completed his university course and then they were married.

Mr. Bryan is principal of a high school and the family has a comfortable income, although medical bills are a strain on the budget. The couple had been saving for their children's education. They hope that their sons will go to a boys' school and then university. As yet, they have no definite plans for their daughters but intend to encourage them in the fields they choose. They seem to feel that education is much more important for boys than for girls.

The Bryan family live in a progressive small town, a short distance from the city. They have all modern conveniences and the town has many activities for both children and adults. Because of his professional position, Mr. Bryan and his family are looked upon as leaders of the community. They are very active in social, church, sport, and community activities.

Psychological Aspects

Both Mr. and Mrs. Bryan were quite distressed when it was discovered that Mrs. Bryan was again pregnant. His wife has had progressive muscular dystrophy for the past few years and had been advised not to have more children. After many consultations with obstetricians, orthopedists, and neurosurgeons, it was decided that the pregnancy would not be harmful. Once they were assured of this fact, they were both excited and happy. This baby would be five years younger than their youngest child so it was "almost as exciting as the first time." Mrs. Bryan was full of enthusiasm, especially since they had always planned on four children. The three other children were just as happy as their parents at the prospect of a new baby. Mrs. Bryan was sure there would be no feelings of hostility or jealousy.

The family seemed to be very happy. Their chief problems were those arising from Mrs. Bryan's illness. Because of her weakness, her husband and children have had to carry an extra load of responsibilities and household duties. However they have done this cheerfully and willingly and seem to be managing very well.

Past Pregnancies

Mrs. Bryan's first baby was full term and in breech position. The labor was long and difficult. It resulted in a forceps delivery during which she lost a considerable amount of blood. She had developed some toxic symptoms antepartum — hypertension, weakness, and edema of extremities. She had been kept on a salt-free diet and bed-rest for three weeks prior to delivery. Postpartum, the patient required several blood transfusions and extra rest to help her regain her strength. The baby was a normal 9 lb. male.

The second pregnancy was much easier. The patient had a normal prenatal period, three-hour labor, spontaneous delivery, and a normal puerperium. The baby was a 5 lb. 12 oz. girl. With her third baby, Mrs. Bryan had a difficult twelve-hour labor, due to complications of which she was not sure. However, the rest of the pregnancy and the puerperium were normal. The baby was a healthy girl, weighing 7 lbs.

Present Pregnancy

Mrs. Bryan did not attend prenatal classes with any of her pregnancies. However, she had detailed instructions from her family physician and he gave her literature on labor and delivery. Being an enthusiastic and cooperative person, she learned and practised the various points regarding breathing and relaxing, before each of her deliveries. She felt she knew what to expect and never had any fear of childbirth. Mrs. Bryan was also very careful about her own personal hygiene and in watching for and reporting abnormal signs and symptoms such as vaginal bleeding, swelling of face, hands or ankles, abdominal pain, headaches and persistent vomiting.

General History

Mrs. Bryan's only physical abnormality was her lower back and leg weakness due to her muscular dystrophy.

Muscular Dystrophy

This is a disease characterized by progressive weakness and atrophy of groups of muscles. The first evidences are increased size of certain muscles, a marked lordosis and waddling gait. The patient falls frequently, has difficulty climbing stairs, and is unable to rise from the ground without "climbing up her legs" with the use of her arms.

Mrs. Bryan thought the disease began following her first pregnancy. At that time she began to fall frequently and was unable to rise without assistance. Since then, she has gradually developped the other symptoms. As yet only her legs are extremely weak. While she is able to walk short distances and lead a relatively normal life, she is unable to do any heavy or strenuous work.

The disease was diagnosed just three years ago. Mrs. Bryan has been seeing an orthopedic surgeon and a neurosurgeon as well as her own physician, since then. She was told that the only treatment for her condition is rest. However, her attitude is marvelous. She realizes the disease is bound to progress but is most optimistic. Both she and her husband have faith that some type of cure will be developed in time.

There is no history of muscular dystrophy in Mrs. Bryan's family although her aunt was believed to have had multiple sclerosis which is somewhat similar.

First, Second, and Third Trimesters

Mrs. Bryan became extremely nauseated with vomiting a few days after her menstrual period was due but had not started. She was sure she was pregnant and went to her family physician. He was inclined to disagree that she would know so soon but gave her a Frog test, the results of which were positive.

Nausea is usually considered to stem from some psychological cause. This may have been the case with Mrs. Bryan. She had been advised by her physician that another pregnancy was undesirable. Naturally, she was very alarmed and frightened at the prospect of being pregnant, the result being nausea and vomiting. She was examined thoroughtly by her physician and her specialists. They felt that if she was able to rest sufficiently, the pregnancy would not cause any harm. Once this fact was established, the nausea and vomiting subsided. Mrs. Bryan began to anticipate the baby with great delight.

She had been advised by her physician to go to a specialist in obstetrics as a precaution in the event of complications. Naturally, the doctor was concerned about her muscular dystrophy and the complications that might arise because of it. Her pelvic measurements were taken to determine any abnormalities in size or shape. All the usual prenatal tests were normal.

She was instructed regarding diet, rest, exercise, and daily hygiene. Because of her muscle weakness, Mrs. Bryan required extra rest and elastic stockings. She was instructed to relieve the pressure on her legs by elevating them whenever possible. This also helped to reduce the swelling of her feet that she experienced.

She was asked to visit her obstetrician every two weeks during her pregnancy and every week during the last month so that he could keep a close check on her progress. Her pregnancy proceeded normally.

Birth of a Baby

Mrs. Bryan began having irregular

contractions at 2:00 A.M. on the day before her actual delivery. She also noticed a pink discharge at the same time. Being a multiparous patient and living out of the city, she decided to come into hospital. She was sent directly to the case room and put to bed. Her contractions were still irregular and the fetal heart sounds were regular at 136 (normal range, 120 to 160). Her vital signs were normal. Her urine was tested for albumin and found to be negative (a positive protein is indicative of toxemia or infection). Mrs. Bryan had had a weight gain of 23 pounds, which was normal.

She was examined rectally and her cervix was found to be one finger dilated. The baby's presentation was determined as vertex; his position L.A.O. and his attitude was complete flexion. The presenting part was still high in the pelvis.

Mrs. Bryan rested during most of the next 12 hours. The fetal heart and vital signs remained normal, her contractions subsided. There was no further vaginal discharge, and the cervix and presenting part remained the same. The fetal heart, contractions, and amount of show were checked every half hour while she was in bed and every hour while she was up.

Late in the evening her contractions started again at regular intervals of 10 to 15 minutes. The fetal heart was 148 and regular and there was some clear show. Special attention must be given to bright red show, meconium, and purulent discharge since these are indicative of antepartum hemorrhage, fetal distress, and infection.

Mrs. Bryan felt abdominal pressure but, on rectal examination, her cervix was still only one finger dilated and thick. In an hour's time her contractions were every five minutes, lasting 35 seconds. She was given Seconal gr. 1½. Seconal is a mild sedative given to promote rest and relaxation. The cervix was three fingers dilated and the presenting part showed ballottement (the rebound of a fetal extremity when displaced by the examining finger, either through the abdominal wall or the vagina).

Mrs. Bryan was becoming quite distressed with her contractions. She was given Demerol 100 mgm. to help relieve the discomfort. There was now a slight amount of mucous show. However, the contractions again subsided and early the next morning they were weak and irregular. By this time the patient was very tired and discouraged. She needed a great deal of assurance and encouragement from the nurses. She managed to rest all day since there was no further development.

Irregular contractions started once more in the afternoon. They were regular and frequent by 5:00 o'clock. This time the patient really entered the first stage of labor that ends with complete dilation of the cervix. Demerol was repeated to relieve distress. Mrs. Bryan was encouraged to breathe abdominally with each contraction to promote relaxation.

At 6:00 P.M. the cervix was four fingers dilated and the show was a clear liquid containing vernix. The appearance of vernix could be an indication of fetal distress, consequently the doctor ruptured the membranes artificially to induce labor. This procedure was done after careful explanation had been given to the patient.

By 7:00 P.M. there was still no change. An intravenous solution containing five minims of Syntocinon, a drug used to induce labor, was started. This was effective and by 8:30 P.M. contractions were very strong. The cervix was effaced, that is, shortened and thinned.

The patient was now in the second stage of labor which begins with complete dilation of the cervix and ends with the delivery of the baby. She was moved to the delivery table. During contractions the patient was instructed to take a deep breath of the anesthetic gas, let it out, take another breath and push. Because of her muscular weakness she had difficulty pushing and her efforts were not too effective. Between contractions she was allowed to rest. By the time the head had crowned, Mrs. Bryan was quite weak and in considerable distress. Trilene, a general anesthetic, was administered and the second stage of labor was completed with the patient under complete anesthesia. The length of the second stage was only 15 minutes and a live male child was born. The delivery was spontaneous, the baby was suctioned and oxygen was given for slight cyanosis.

Ergotrate 0.2 mgm. was administered intravenously to the mother at the time of delivery. This was given to hasten expulsion of the placenta and it was expelled spontaneously three minutes later. Ergotrate is usually given at the crowning of the head but in this instance there was not time. The 32-ounce placenta was complete, healthy; the membranes were intact. The fact that it was complete was very important since if part of the placenta remains in the uterus, it could result in hemorrhage. During the delivery, a midline episiotomy had been made. This was repaired following delivery of the placenta.

Mrs. Bryan's blood loss was estimated at 150 cc. which is normal. Postpartum hemorrhage is said to have occurred when the blood loss is over 500 cc. Immediately postpartum, Mrs. Bryan's perineum was cleansed, a clean pad applied, and she was covered with a warm sheet. Her fundus was four fingers below her umbilicus and firm. Her lochia was moderate although her abdomen was very lax. Her blood pressure was elevated so she was given morphine shortly after delivery. Following the initial postpartum check, she was given a sponge bath, mouth care, perineal care and breast care.

A final check showed Mrs. Bryan's fundus to be five fingers below her umbilicus, her lochial discharge moderate, blood pressure 158/100, her pulse 108, and her condition satisfactory. She was transferred to a semi-private room on the ward at 10:30 P.M.

Upon arrival on the ward, her condition was again checked. This was to determine any changes due to movement and transportation. At 11:00 P.M. her blood pressure was normal and the intravenous was discontinued. She was given a sedative and a mild analgesic for perineal discomfort. She voided without difficulty a few hours later. Inability to void after delivery may indicate stretching of the urethra.

During the following days, Mrs. Bryan was given routine postpartum care. Her breasts, fundus, lochia and perineum were checked each morning. She was taught to carry out perineal care which she did four times a day. She received a mild analgesic as necessary for after-pains.

On her third day her breasts began to fill and gradually became engorged and tender. Since she was not breast feeding, Mrs. Bryan was given camphor rubs, and wore a tight binder. She had been taught to wash her breasts carefully each day with Gamophen soap. She used an anesthetic ointment and a heat lamp to promote healing of her perineum.

Usually, patients go to the physiotherapy department on their fifth day for exercises to aid involution but Mrs. Bryan was unable to participate because of her muscular weakness. She was up for short periods each day but was encouraged to rest. Early ambulation has several advantages:

1. Better drainage of lochia, therefore more rapid involution;
2. reduction of respiratory complications;
3. provision of better circulation which helps to prevent thrombosis;
4. more rapid resumption of bladder and bowel function.

Postpartum Surgery

On her fourth day Mrs. Bryan went to the operating room for a tubal ligation. This operation was necessary because of her progressive muscular condition. Further pregnancies would definitely endanger her life and that of unborn children. The necessity of the operation had been decided beforehand and both Mr. and Mrs. Bryan were very much in favor of it.

The patient's postoperative condition was very good. Her vital signs were stable. There was no oozing on her abdominal dressing and her catheter was draining well. When she was fully conscious an abdominal binder was applied for support. The catheter was accidentally dislodged six hours postoperatively and since she was able to void voluntarily, it was not replaced. Chloromycetin, 250 mgm., every four hours was given to prevent infection.

By her postoperative third day Mrs. Bryan was up short periods. She suffered only minor abdominal discomfort. Her chief complaint was of a stiff neck which was most uncomfortable. She received an analgesic, heat, massage, and physiotherapy exercises over the next few days. It was felt by her obstetrician that this complication might be due to her muscular dystrophy. He made arrangements to have further investigation done.

Mrs. Bryan was discharged from hospital two weeks following her admission. Although she had to walk slowly, she was fairly strong, felt well, and was beaming with excitement and happiness. She had missed her family very much and could hardly wait to get home to them. Also she was excited about having a new baby to show off and care for. Her spunky spirit contributed much to her good recovery from both the delivery and the operation.

In Memoriam

Helen Arnoldi, a graduate of the Montreal General Hospital in 1915, died suddenly in Trenton, Ont. on August 27, 1961.

* * *

Maude Anne Bridgman who graduated from Royal Inland Hospital, Kamloops, B.C. in 1922, died in Vancouver on September 14, 1961.

* * *

Alberta May (Strickland) Cassidy, a 1950 graduate of Portage la Prairie General Hospital, Manitoba, died on September 9, 1961 from injuries received in a motor accident. She had engaged in institutional nursing.

* * *

Agnes (Johnson) Ellis who graduated from St. Joseph's Hospital, Victoria, B.C. in 1902, died on September 2, 1961 in Victoria. Mrs. Ellis was the first student to enter the school of nursing when it was inaugurated in 1900. She was 93 years old.

* * *

Jeannine Fredette, a 1952 graduate of Hôpital St-Charles, St. Hyacinthe died in Sherbrooke, Que. in September 1961 as the result of an accident.

* * *

Marjorie Helen Harris, a 1918 graduate of Vancouver General Hospital, died in Vancouver on September 9, 1961. She was on the staff of the B.C. Telephone Company Employees Medical Plan.

* * *

Elizabeth Audrey (Rutherford) Jaimet, a 1934 graduate of Toronto General Hospital, died May 28, 1961.

* * *

Marguerite Kelly, a graduate of Hôtel Dieu Hospital, Windsor, died recently in London, Ont. She was the director of the Community Nursing Registry in Windsor for the past nine years and also its registrar. For several years she was on the staff of the Detroit Board of Health.

* * *

Winnifred A. M. Lee who graduated from the Montreal General Hospital in 1913 died in Montreal on July 17, 1961.

* * *

Ethyle (Percival) LeMee, a 1928 graduate of the Montreal General Hospital, died July 31, 1961.

* * *

Olive L. Niles who graduated in 1901 from Rhode Island Hospital, Providence, R.I. died September 10, 1961 in Toronto. She was a member of QAIMNSR during World War I.

* * *

Kathryn (Sharp) Scharf, a 1937 graduate of Kingston General Hospital died recently in Calgary following a brief illness.

* * *

Amanda Séguin who graduated in 1913 from Notre Dame Hospital, Montreal, died September 19, 1961 after a long illness. Miss Séguin took an active part in the organization of the ANPQ. She engaged in public health nursing during her professional career.

* * *

Beatrice Ann Stewart, who graduated in 1928 from Grace Hospital, Toronto, died on June 30, 1961.

* * *

Anne (Hayes) Sullivan, a 1915 graduate of St. Michael's Hospital, Toronto, died on June 5, 1961. Her professional life was spent in private nursing.

* * *

Beatrice (Creasy) Taber, a graduate of Winnipeg General Hospital in 1929, died on June 4, 1961.

* * *

Elizabeth Maud Thompson, a 1918 graduate of Riverdale Hospital, Toronto died on July 24, 1961 at Durham, Ont. She was a charge nurse at Riverdale Hospital until her retirement in 1953.

* * *

Florence B. (Fannon) Thompson who graduated from St. Michael's Hospital, Toronto in 1931 died on July 25, 1961. She had engaged in private nursing.

NURSING PROFILES

The Quarantine and Immigration Services of the Department of National Health and Welfare, Ottawa, recently added a nursing position to the Canadian unit in Hong Kong. **Eleanor Purcell,** a nursing counsellor in the Civil Service Health Division of the Department, has been appointed to initiate the new service. She began her new duties in September 1961.

(Paul Horsdal Ltd. Ottawa)

Eleanor Purcell

Miss Purcell is a graduate of the Cottage Hospital, Pembroke, Ont. After several years as surgical supervisor in her Alma Mater, she joined the RCAMC and served in England and North West Europe during World War II. Her association with the Department of National Health and Welfare began upon her return from overseas. Miss Purcell retained her connection with the military and for the past 11 years she has been matron of No. 10 Medical Co., RCAMC (Militia). She has been active in the work of the St. John Ambulance Brigade and, for several years, has taught courses in home nursing.

Margaret D. McLean was recently appointed nursing consultant (Hospital Insurance) with the Department of National Health and Welfare. A graduate of the Royal Victoria Hospital, Montreal, Miss McLean received her B.Sc. N. from the University of Western Ontario and her Master's degree from Teachers College, Columbia University. In addition she has had further study in nursing service administration and methods improvement.

Her professional career has included teaching duties at the Provincial Mental Hospital, Ponoka; the Toronto General Hospital and the University of Western Ontario School of Nursing where she was associate professor of nursing for eight years. Experience in nursing service was obtained in the Royal Canadian Navy, Berwick Hospital, Berwick, Penna., and in hospitals in Costa Rica. For the past five years Miss McLean has been a nursing consultant with Gordon A. Friesen Associates, Hospital Consultants, Washington, D.C.

Margaret McLean

The University of Alberta School of Nursing has announced the appointment of two new staff members, **Betty Harrington** and **Madeleine Ruth Geddes.**

Miss Harrington, who is a graduate of the Royal Alexandra Hospital, Edmonton, studied public health nursing at the University of Alberta and later obtained her bachelor's degree in nursing from McGill University. She majored in administration and supervision in public health nursing.

Her past experience has included institutional and private nursing, health nursing and teaching in Calgary. During 1954-61, Miss Harrington did public health nursing in

Victoria, B.C., for the past two years on a supervisory level.

Miss Geddes is a graduate of the University of Alberta Hospital, Edmonton and holds her B.Sc. from U. of A. Shortly after her graduation in 1956, she joined the Victorian Order of Nurses and worked as a staff nurse in Sudbury, Ont. for about 18 months. In 1959 Miss Geddes joined the staff of the Alberta Children's Hospital, Calgary and eventually rose to the position of a head nurse. One year was spent in travel abroad with some nursing experiences in hospitals in London, England.

The Winnipeg branch of the Victorian Order of Nurses has a new director — **Margaret (Perfect) Mackling.** Mrs. Mackling is a 1946 graduate of the Winnipeg General Hospital and holds a diploma in public health nursing from the University of Manitoba and a bachelor of science in public health nursing from the University of Minnesota. She has been on the staff of the Victorian Order of Nurses ever since her graduation.

She is a past president of the Manitoba Public Health Association and the current secretary of the Nursing section, Canadian Public Health Association.

MARGARET MACKLING

Dorothy Marion Dewar Hopkins, whose association with the health services of Saskatchewan dates from 1927 when she was appointed public health nursing consultant, School Hygiene Branch of Saskatchewan Department of Education, has retired. In 1928, one year after her appointment, she transferred with the School Hygiene Branch to the provincial Department of Public Health, Division of Public Health Nursing. In 1944, Miss Hopkins became a supervisor and in 1959 she was named nursing consultant to the Department.

(Sask. Govt. Photo)

DOROTHY HOPKINS

Miss Hopkins took teacher's training at the Saskatoon Normal School and taught school in the province for three years before entering the Toronto General Hospital School of Nursing. Following her graduation in 1925, she did general nursing on the surgical and medical wards of T.G.H. and some private nursing before going to Saskatchewan. Over the years, Miss Hopkins added to her general nursing experience through study at the University of Toronto where she obtained her public health nursing certificate; at Northwestern University Medical School, Chicago where she obtained special preparation in the Kenny method of polio treatment; and at various other centres offering courses particularly useful to her in her professional career.

An acknowledged expert in the field of public health nursing, Miss Hopkins was responsible for a number of innovations in its practice. The high standard of achievement that she set for public health nursing played a major role in increasing public demand for health services. Her many friends and associates wish for her continued good health and happiness, and are confident that she will continue to make a valuable contribution to public health.

Mona Gordon Wilson, M.B.E., O.B.E., has retired from her position as director of Public Health Nursing, Provincial Department of Health, P.E.I. A Canadian graduate of Johns Hopkins Hospital, Baltimore, Maryland, Miss Wilson studied public health nursing at the University of Toronto. A travelling fellowship from the Rockefeller Foundation provided the opportunity for further observation and study.

Miss Wilson gave outstanding nursing service in both world wars. She was a nursing sister with the U.S. Army Corps in France 1918-19 and an American Red Cross Nurse in Yokohama, Vladivostock, Montenegro, Dalmatia, Albania and Paris 1919-22. On her return to Canada following World War I, she joined the Canadian Red Cross Society and did public health nursing under its auspices in Prince Edward Island 1923-31. World War II saw Miss Wilson again in service with the Canadian Red Cross — this time in Newfoundland.

A past president of the ANPEI and of the New Brunswick - Prince Edward Island Branch, Canadian Public Health Association, Miss Wilson has also served on numerous nursing committees. She is an honorary life member of the CPHA and a member emeritus of the N.B.-P.E.I. Branch. Work with the Girl Guides has taken up much of her spare time. She was a former provincial commissioner and is presently chairman of the provincial awards committee and a member of the provincial branch of the International Committee of the Girl Guides. She is also a member of the Canadian Club.

Her many friends and associates wish her well in the future.

(Frances Davies, Charlottetown)

MONA WILSON

Coming!

in

JANUARY 1962

Guest Editor — Miss Helen Carpenter, President, Canadian Nurses' Association

Miller — The Patient's Right to Know the Truth

Klassen and Nicholson — Stokes-Adams Syndrome

Solomon — The Professional School in the University

Villeneuve — Motivating Employees to High Levels of Achievement

Plus additional material

FOOD AND DRUGS ACT

Schedule G, which has been added to the *Food and Drugs Act,* lists as "Controlled drugs" 1. Amphetamine and its salts 2. Barbituric acid and its salts and derivatives 3. Methamphetamine and its salts. Copies of Chap. 37 of the Act may be obtained from the Queen's Printer, Ottawa, Price 25 cents.

Abdominal Decompression During Labor

SISTER M. ASSUMPTA, B.SC. *and* MARGARET HOWARD

St. Mary's Hospital, Montreal, has been the scene of improvements and tests on a new apparatus that accelerates the first stage of labor.

THIS IS A PRELIMINARY report describing the new type of decompression apparatus which, it is believed, reduces the pain of parturition and offers several important improvements over previous equipment. The results are "very encouraging" and further trial is warranted as it "may be a very important addition to the conduct of the first stage of labor."

History

This work was undertaken as the result of an original publication in April 1959 by Professor O. S. Heyns of Witwatersrand University, Johannesburg, South Africa. Observation, during experiments using muscle relaxants, suggested that abdominal wall relaxation would produce a marked acceleration of the first stage of labor. A search was undertaken to find a safe method of relaxing the abdominal musculature. From this has evolved the technique of abdominal decompression.

Theory of Action

In the resting state the uterus is approximately ellipsoid in shape with the upper segment at an angle backward from the lower segment. During a contraction the uterus tends to become spherical and rises forward eliminating the angle between upper and lower segments. A tense abdominal wall will resist these changes and the contracting uterus will expend a portion of its energy in overcoming this resistance.

A number of methods now in use attempt to solve this difficulty by encouraging the mother to relax. These include relaxation exercises, natural childbirth methods, hypnosis, and sedative drugs. Decompression produces relaxation of the abdominal wall by mechanical means. Unlike the others, it is largely independent of the mother's emotional status. Its use simply requires a patient who is cooperative and intelligent enough to manipulate the apparatus. A language barrier is not a drawback.

Results tend to show that this method considerably relieves the pain of labor, but as yet there is no definite explanation for this.

The First Decompression Suit

The mother was zippered inside a plastic suit which extended from the axillae down to and enclosing the feet. The suit was separated from the abdomen by a rigid spacer. Air was pumped out creating a partial vacuum over the body. The mother worked the pump herself when the contraction began. This resulted in a sucking force on the abdomen which caused it to bulge outwards where the wall was muscular and able to stretch.

Experiments began at St. Mary's Hospital in the summer of 1959. The South African equipment was not available at that time, so our obstetricians designed and constructed their own. This consisted of a wood and metal spacer that was adjustable to fit all sizes of patients. The spacer was supported by a hinged backboard for use on a hospital bed. Various designs of airtight plastic suits were tried before a model was evolved that was considered to be satisfactory. This was a soft vinyl plastic bag, with a four-foot zipper down the front, totally enclosing the patient to the axillae. A high vacuum pump capable of evacuating 75 litres per minute was used. The apparatus was designed for use with the patient sitting at an angle of 55°. This angle was chosen to bring the long axis of the uterus approximately into line with the axis of the pelvis. The patient was placed on the backboard. The spacer was placed over her abdomen and enclosed in the plastic suit. The vacuum pump was connected. The pump operated continuously and when a contraction occurred the patient closed a valve producing a vacuum extending from the lower chest to the vulva. The operating pressures were usually in the range of 50 to 70 mm. of mercury below atmospheric pressure.

A further modification of the original models was tested. This suit extended from the axillae to the level of the upper thigh but was rejected as unsatisfactory.

Disadvantages of the Suit

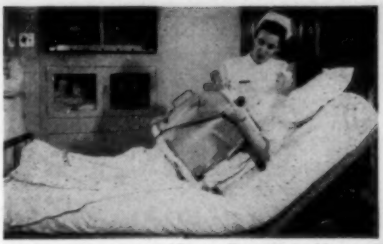
The suit was used in the first 40 cases. The initial 20 are not included in our statistical analysis due to incomplete documentation during the preliminary part of this investigation. The disadvantages evidenced by experience were:

1. A feeling of pressure on the chest at the upper end of the suit. This made breathing difficult and proved unbearable in some cases which required removal of these patients from the suit.
2. The inability to examine the patient rectally or vaginally or to auscultate the fetal heart without partially dismantling the apparatus.
3. The accumulation of *liquor amnii* within the plastic suit.
4. The immobilization of the legs by the closely adherent plastic bag.
5. In the short plastic suit, compression and discomfort around the upper thigh seal was especially noticeable and considered dangerous to those with varicose veins.

New Apparatus

These disadvantages stimulated a search to modify the apparatus while utilizing the existing principles. A prototype model of our new apparatus has been constructed. It eliminates the troublesome features of the former one. The last 31 cases of this series have used it. The plastic suit has been discarded entirely.

The new apparatus consists of a dome constructed of a special thermo-plastic material that combines rigidity with flexibility. This has enabled us to use one size of dome to fit 80 per cent of patients. However, three sizes of domes have been considered in the budget, since they will probably be necessary to fit all sizes of patients satisfactorily. The decompression dome is constructed so that it can be used on a regular hospital bed, with the patient sitting at an angle of 55 degrees. A rigid backboard, padded with sponge rubber is placed under the patient extending from the shoulders to the buttocks. The plastic dome is placed over the abdomen and sealed to the patient by a thick non-porous sponge rubber margin. The seal is in contact with the patient from the base of the breasts, down to the flanks, and across the abdomen at the level of the pubis. Therefore, only the lower half of the chest and the abdomen are enclosed within the dome.



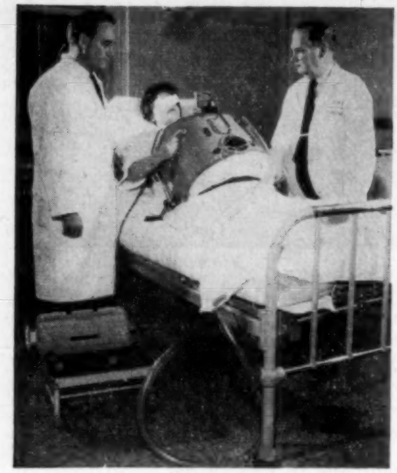
(Graetz Bros. Ltd., Montreal)

Figure *1: The patient holds the starting switch in her hand ready to activate the motor thereby evacuating the air from the chamber so as to relax the abdominal muscles. The responsibility for operating the equipment rests with the patient whose actions are directed by a need to relieve the labor pains.*

The chamber is adjusted by two canvas straps. These pass around the patient's back and tighten the dome to her sides. Two slidings locks, one on either side, fasten the chamber to the backboard and thus press the sponge rubber seal more securely against the patient, so as to make the dome airtight.

The area enclosed by the dome is evacuated of air by means of a plastic hose connected to a domestic type vacuum cleaner. The high evacuating capacity of the vacuum cleaner, 1800 litres per minute displacement, has made it superior to the previously used 75 litres per minute high vacuum pump. Suitable levels of vacuum are achieved within seconds. Small leaks at the sealing edge can be ignored.

The patient operates a push-button switch to start the vacuum with each contraction. This lifts her up against the seal and arches her back. Between contractions the motor is switched off by the patient. (Fig. No. 1) The vacuum cleaner can give a maximum



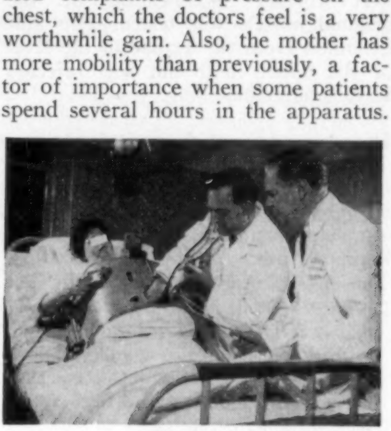
(Graetz Bros. Ltd., Montreal)

Figure 2: *The dome-shaped unit is constructed of a thermo-plastic material. It has plastic tubing leading to a vacuum cleaner unit. No weight is imposed on the abdomen of the patient. She is enclosed in the air-tight dome that rests against the supporting backboard.*

vacuum of minus 90 mm. of mercury, that is, below atmospheric pressure. The usual operating range is minus 35 to minus 75 mm. of mercury. The higher levels of vacuum become necessary for pain relief as the strength of contractions increases. The patient observes a gauge mounted directly on the dome and operates a release valve. This allows air to enter the dome to maintain the vacuum at the required level. (Fig. No. 2)

The vacuum within the dome creates a downward counter pressure that is felt by the patient where she is in contact with the sponge-rubber seal. This pressure is uncomfortable. A rigid backboard and adjustable side supports were designed to overcome it. The pressure is transmitted direcly from the dome to the backboard and satisfactorily eliminates the discomfort felt by the patient.

From the patient's point of view, the new chamber has practically eliminated complaints of pressure on the chest, which the doctors feel is a very worthwhile gain. Also, the mother has more mobility than previously, a factor of importance when some patients spend several hours in the apparatus.



(Graetz Bros. Ltd., Montreal)

Figure 3: *The opening in the decompression chamber is used to palpate the baby and to check the fetal heart.*

The role of the medical attendant is considerably simplified because of the ease of examination of both the mother and the fetal heart through a trapdoor that has been built into the dome. (Fig. No. 3) These are improvements effected by the Canadian doctors over the product of the South African experimenters. In the plastic suit method, the vulva and the perineum are included in the decompressed area. With the decompression dome, these areas are at ordinary atmospheric pressure. This probably has an important effect on the pelvic floor which bulges down in the plastic suit method. The opposite effect probably occurs in the decompression dome, but further research on this point is needed.

CLASSIFICATION OF RESULTS

Table 1

Time from Start of Decompression (4 cm. or less) to Full Cervical Dilatation

Class I	0 - 3 hours
Class II	3 - 5 hours
Class III	5 - 7 hours
Class IV	7 + hours

Table 2

Patient's Estimation of Pain Relief

Excellent	75 +% relief of pain
Good	50-75% relief of pain
Fair	25-50% relief of pain
Poor	0-25% relief of pain

Table 3

Elapsed Time from Start of Decompression (4 cm. or less) to End of First Stage

		20 Cases Plastic Suit		31 Cases Decompression Chamber		Combined	
		Primip	Multip	Primip	Multip	Primip	Multip
I	(0 — 3 hrs.)	4	1	8	13	12	14
II	(3 — 5 hrs.)	4	2	6	1	10	3
III	(5 — 7 hrs.)	2	—	2	—	4	—
IV	(7 + hrs.)	1	1	—	1	1	2

5 cases of failure

Case No. 6 (Suit) Unable to stand pressure sensation on chest.

Case No. 8 (Suit) Slow progress. Abandoned after three hours of decompression because of inability to stand pressure on chest. Was progressing.

Case No. 24 (Suit) and *Case No. 38* (Suit) Elderly primiparas failure to progress — Caesarean Section.

Case No. 15A (Suit) Abandoned because of fall in blood pressure.

Table 4

Estimated Pain Relief

	Plastic suit 15 cases		Decompression Chamber 31 cases		Combined 46 cases		Percentage		
	Primip	Multip	Primip	Multip	Primip	Multip	Primip	Multip	Total
Excellent	4	2	6	7	10	9	22 %	19.5%	41.5%
Good	5	1	9	5	14	6	30.5%	13 %	43.5%
Fair	2	1	1	3	3	4	6.5%	8.5%	15 %
Poor	—	—	—	—	—	—	—	—	—

This gives the impression that in many cases the process of labor is considerably speeded up. The majority of patients obtain relief of pain and in some cases this is considerable. Full evaluation of decompression may prove difficult because it is not known how a given patient would have behaved in the absence of decompression treatment. A simple observation may be deceptive and, therefore, our obstetricians felt that they should evaluate a series only with proper controls and in statistically significant numbers.

Comment

As noted above, it would be unjustified to draw firm conclusions. However, the following trends may be noted:

1. Only seven of the forty-six patients (15.2%) who reached full dilatation took more than five hours to do so. Five were primiparas and two multiparas.

2. Only seven out of forty-six (15.2%) had less than good relief of pain. The majority of these failures can be explained on grounds of technical inadequacy of equipment. This can be corrected. Three were primiparas, and four multiparas.

3. Only twenty-one of forty-six patients (45.6%) received any sedation. Many of these could have managed without it.

4. A few tentative experiments to induce labor have been made. An early impression is that the method seems capable, in some instances, of converting prodromal labor into an unequivocal type of labor. It is possible that this has been inadvertently done on a number of occasions. Some of the more lengthy labors have fallen into this category. This is largely a problem of multiparas and further experience will, in all events, eliminate these.

5. Average time of decompression (from 4 cm. or less to full dilatation):

Primigravida	2 hr. 56 minutes
Multipara	1 hr. 57 minutes

6. It would appear that labor is stimulated by this technique; that contractions appear more frequently, last longer and are apparently stronger.

7. After delivery by the decompression method, the patients were carefully examined to exclude any possible damage to the genital tract. Only one case of cervical laceration was found. This was associated with a forceps delivery and manual removal of a trapped placenta.

Summary

The principles of abdominal decompression have been discussed. A new method for decompression, using a thermo-plastic chamber that fits over the breasts and abdomen has been described. The technique gives very substantial relief of pain. Sedation was not required in 45 per cent of the cases, while in the remainder it was minimal. The first stage of labor was markedly accelerated in primigravida, and to a lesser extent in multigravida.

Nursing Care

Introduction

The first stage of labor (dilating stage) begins with the first symptoms of true labor and ends with the complete dilatation of the cervix. The obstetrician examines the patient early in labor and sees her from time to time throughout the first stage. He is not necessarily in constant attendance at this time. He must rely on the nurse to be the zealous guardian of the welfare of the mother and baby and to notify him concerning the progress of labor.

One of the first responsibilities of the nurse is to recognize that, in addition to the physical manifestations, there are spiritual, social, economic and emotional factors that influence each mother's pregnancy. All of these have a bearing on her individual needs for care. The nurse who is cordial, empathic and interested in the welfare of her patients, establishes good rapport with relative ease. Without prying, she is able to secure information that will enable her to gain greater insight into individual nursing needs. She must be constantly alert to symptoms associated with the progress of normal labor. At St. Mary's Hospital, no solid food is given to any patient in labor except on the direct order of the attending obstetrician. Fluids may be given in limited quantities.

Decompression Dome

Before the patient is placed in the decompression chamber, she is visited by her obstetrician who explains the function, purpose and results of the machine. The apparatus is designed to produce relaxation of the muscles of the abdominal wall, thus shortening the first stage of labor and relieving the pain 50-70 per cent. Because of this, the nursing care of the patient in labor is changed and somewhat minimized. However, the most important aspect of all nursing care remains — to care for the mental attitude and physical welfare of the patient. This is very important to the patient in the decompression chamber. She is experiencing something new and different. Naturally, she does not completely trust it. At first, she is markedly apprehensive upon experiencing this "different" feeling of having her abdominal wall, as it were, "suctioned" away from her. She sometimes becomes panicky and needs continued reassurance from the nurse. Diaphragmatic breathing may appear difficult for the mother at first. Encouraging her to change to rapid, shallow costal breathing usually produces effective results and puts the mother at ease. Initially, the patient looks to the nurse for guidance. She will cooperate well if told what to expect and what progress is being made. Later, when she becomes accustomed to the decompression chamber, the patient needs very little reassurance or encouragement in connection with her labor.

Other points of importance to observe are:

1. The patient should be urged to empty her bladder before the plastic dome is placed over her abdomen.
2. Check and record fetal heart, blood pressure and pulse and the quality of uterine contractions.
3. Be sure that the decompression chamber remains properly fitted to the patient during labor in order to maintain good air seal.
4. As labor progresses, explain to the patient how to readjust the gauge that regulates the pressure in order to obtain maximum relief.
5. Observe progress of labor closely and report on the general character of the labor contractions, the amount and type of discharge and appearance of any other signs.
6. The nurse should watch for the patient bearing-down and for bulging of the perineum. These are signs of the second stage of labor. If the patient is a primipara, she remains in the chamber until she experiences a bearing-down sensation. Then the obstetrician is notified, the plastic dome removed and the patient transferred to the delivery room.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Season's Greetings

National Office staff extends greetings to nurses everywhere for a holy and joyful Christmas season. A Happy Christmas to you all.

CNA Committees

When the month of December opens its doors most people, knowing that Christmas is on their doorstep, begin to think seriously about their Christmas shopping. However, the members of the CNA Committees on Nursing Service and Nursing Education had other things on their minds. Both committees were meeting in CNA National Office, discussing matters of importance to nursing.

As they did last year, the Committees met jointly and also held separate sessions. This being the last opportunity for all the members to meet together before the end of the biennial period, the committees were concerned with the completion of projects undertaken in the fall of 1960. The results of these projects will be presented to the CNA Executive Committee which meets in February. You will be learning more about them in the coming New Year and during the CNA Biennial Meeting in Vancouver, June 25-29, 1962.

Progress reports of CNA's three major projects: the school improvement program, the study of the whole field of nursing education; and the study of the evaluation of nursing service in the areas where students in schools of nursing receive their clinical experience, were given by Miss Glenna Rowsell, Miss Helen Mussallem and Miss Lillian Campion respectively.

The Sub-committees of the Committees on Nursing Service and Nursing Education held meetings during the year at which considerable attention was given to the various projects undertaken.

You will be learning more about the revision of policies regarding nursing education, an annotated bibliography on curriculum development and a manual entitled "Characteristics of a Good School of Nursing." These projects were undertaken by the Committee on Nursing Education.

In the area of nursing service, a series of articles on "Evaluation" and a bibliography on "In-Service Education" will be published in forthcoming issues of *The Canadian Nurse*. A statement on the "Philosophy of Nursing" and a brochure on "Continuity of Care" (The Nurse and Community Resources) are ready for presentation to the Executive Committee prior to circulation.

ICN Exchange of Privileges

One of the privileges that Canadian nurses share with nurses from the other ICN member nations is the opportunity to work and study abroad. Have you been wondering about going to some other country to work? This message will help to clarify your ideas and guide you in your planning.

Frequently, nurses by-pass their provincial or national associations and write directly for information regarding work abroad. They have often been discouraged or disappointed when opportunities to work or study were denied them. The Exchange of Privileges program calls for letters of application received by foreign hospitals from individual Canadian nurses to be forwarded to the nurses' association of the country concerned. That association refers the letter to the Canadian Nurses' Association. Advance planning through the right channels would thus prevent unnecessary delays and frustrations.

Arrangements made through your national association for employment or study abroad are protected. Participating national associations follow up the negotiations and recommendations made by the CNA for its members. Remember, nurses working abroad are ambassadors of Canada and Canadian nursing, and our professional status is judged by the performance of our members.

CNA has had the privilege of welcoming to Canada and initiating programs of observation for the following nurses within the last three months: Miss MABEL WILSON, Registrar, General Nursing Council for Scotland; Miss FERNANDA ALVES-DINIZ, Regional Nursing Officer, WHO Regional Office for Europe, Portugal; Miss SYLVIA CURLEY, deputy matron, Canberra Community Hospital, Australia; Miss KATHERINE BARTLETT, operating theatre superintendent, England; Miss CAROL BROWN, supervisor of hospital nursing services for Trinidad; Miss GWENDOLINE GARDINER, deputy matron, England; Miss NANCY LONG, dean, Northern District School of Nursing, Australia.

It has also been our pleasure to sponsor Miss EDITH CARLIN of Alberta who after completing her course in orthopedic nursing at Oswestry, England, undertook a 6-weeks study tour of observation in other orthopedic centres in England; and Miss SUZANNE JACQUES, a Victorian Order Nurse from Prince Albert, Saskatchewan who has enrolled in a course in Plastic Surgery in Chepstow, England.

Visits in Denmark were planned for Miss LILLIAN McKENZIE, director, public health nursing, Winnipeg and Mrs. HELEN GEMEROY, supervisor of nursing. Allan Memorial Institute, Montreal, each in their own area of interest.

Extension Course in Nursing Unit Administration

The first intramural session of the course in Nursing Unit Administration, jointly sponsored by the Canadian Hospital Association and the Canadian Nurses' Association and financially supported by the W. H. Kellogg Foundation, was held on a regional basis last September. This in-service type of program is designed to assist head nurses and supervisors to improve their administrative skills. Three hundred and twenty-four nurses attended the five-day workshops that were held in Vancouver, London, Toronto, Winnipeg, Halifax and Edmonton.

The aims of the course and the method of presentation were outlined. Students were introduced to the qualities of leadership with applications made to the function of the head nurse. Attention was given to the impact of social forces on nursing and the need for nurses to adapt to changing concepts. The home study session of the course commenced in October and will extend over a seven-month period. Lessons are mailed to the students at two-week intervals. The student is asked to complete an assignment at the end of each lesson. The assignment relates to the work situation and takes the form of a problem to be solved, questions to be answered or a report on a project. All completed assignments will be reviewed by an examiner who will evaluate the quality of the work done and make appropriate comments to assist the student in improving her written assignments. A final workshop — also of five days — will be held at the end of the extramural period. At that time, experts in related fields will deal in greater detail with certain subjects covered in the written lessons.

CNA Retirement Plan

It is urgent that members participating in the CNA Retirement Plan "A" notify National Office of any change of address in order that T-4 income tax slips may be forwarded in time for exemption claim.

What begins as a study of good health should end up as a consideration of a good life. Health is a means — not an end.

— GORDON WRIGHT

A Chaplain Interprets His Work

Earle T. McKnight, B.A., B.D.

The specific role of the chaplain in a psychiatric hospital is helping people come to a healthy relationship with God.

It is generally recognized that health is related to a wholesome pattern of life. A person's pattern of life is the dynamic interaction of his *relationships* with himself (intrapsychic), his fellowman (interpersonal) and his God (religious). A wholesome pattern of life is achieved when there is a healthy functioning of all of these relationships. Dis-ease between parts of one's self or between one's self and others, including God, creates ill-health in the personality; on the other hand, good, healthy relationships in any area of one's life contribute to good health of the whole personality. Thus, a selfish person tends to seek selfish ends in his religion and a person who has had a very unpredictable and domineering parent or guardian will find it hard to trust himself to God as a Being who is reliable or good. One whose relationships with himself or with others are rigid, hostile, over-dependent, fearful or obsessive will tend to have relationships with God that are similarly unhealthy. Conversely, coming into helpful contact with a wholesome person will assist in the healing of emotional and organic illness, and also contribute to the wholesomeness of one's religious life. Coming into a healthy relationship with God is even more effective in this respect, and is the path to ultimate health. The specific role of the chaplain in a psychiatric hospital is that of helping people come to a healthy relationship with God. When the chaplain seeks this aim he feels that he has an integral part to play in the total program of helping the mentally ill.

The establishment of healthy relationships is no small part of the contribution that nurses make to the welfare of the patient. Probably no one enters more deeply into the confidence of patients than their nurses and hence, no other relationship is of greater importance in the ultimate outcome of their conditions. I am certain that, if you are not too modest, you could recall patients whose health was regained largely through the relationship which you established with them during your nursing duties. From this experience and observation, you can appreciate the effect of a healthy human relationship upon healing.

Chaplains sometimes have a similar experience. A patient who had been in several mental hospitals wrote his sister just prior to discharge from the last one:

> This time when I leave the hospital it will be the first time I'll be leaving one of these places without a worry or a care and that I'm not afraid of anybody or anything. Maybe it's because of the minister that holds services there, he . . . has had various talks with me and for the first time in my life I believe in God and the Bible.

Clinical studies are confirming the fact that wholesome human relationships and wholesome religious life both make for healing.

The Scriptures tell of many illnesses that followed inadequate relationships with men and with God, as evidenced in descriptions of emotional states such as excessive guilt, depression, and crippling self-consciousness. The Bible is a rich case-book of examples describing people who were healed of various diseases when they had straightened out their relationship with God. The diseases range from paralytic conditions to hemorrhage, from "possession by demons" (with many manifestations of a psychotic nature, including seizures) to leprosy. Jesus, Who made so many of these healings possible, told people it was their relationship to God (faith) that effected the change. He has been appropriately called "The Great Physician." Chaplains of the Christian faith-group feel a special responsibility to carry through His command to "preach, teach, and heal." Those of us who are privileged to work in psychiatric hospitals have the unique opportunity of seeing how these three activities converge in helping people to come to a healthy relationship with God.

The Chaplain in the Hospital

There are four main areas of work that chaplains are attempting to do in the hospital:

First, *to be there* — to walk the corridors, to be on the wards, to greet one or many, to listen or counsel or pray — as a person who cares, but more, as the one who is there as a pastor of God. We try to make an initial call on each patient of our faith-group within a week after admission. Our presence may produce negative reactions in those who have had unhappy experiences with clergymen or the church, or who feel guilty. Since these unhappy relationships have contributed to the patients' illness, our being there and accepting them as they are is evidence that God hasn't deserted them — that He accepts them as they are and that it is safe for them to reconsider their past. By our presence we are trying to say that there is hope for the future, both here and hereafter. We hope to help them establish a healthy relationship with God, beginning with a desirable relationship with us.

Second, *to conduct the ministries of religion*. Chapel services offer many possibilities of helping patients gain, or regain, healthy relationships with God. Some have had no mature religious experience or training. Some have had very unhealthy religious influences. Some have reacted against, or had some form of trouble with, previous religious life. The familiarity of the various parts of the service, group participation in prayers and hymns, and the social experience of the chapel service are potentially helpful experiences, even though they sometimes stir a patient deeply. Actually, there is a danger of short-circuiting the work of nature's mechanisms, such as appropriate guilt, fear, and anger, by sedation, or tranquilizers or by assuming that all are neurotic symptoms. The service of worship is able to deal with these basic human emotions indirectly through religious symbols and terminology and directly through preaching. The service of Holy Communion is a most effective way of dealing with basic human emotions, especially guilt, through religious symbols. The chapel service may also help people bring to completion "guilt work" that was never satisfactorily handled following a bereavement, divorce, amputation, or similar loss.

Third, *pastoral counselling*. As you observe us going through the ward, you may feel that our contacts are superficial. You are correct about many of them — just the contact itself may be all that we feel is needed, or all we have time for. But there are patients who need and can be helped by pastoral counselling. The American Psychiatric Association has devoted two of its annual Religion-and-Psychiatry sessions to "Psychotherapy and Pastoral Counselling," and has not succeeded in differentiating clearly between the two functions. However, I dare to suggest that both are "in depth" — both the pastor and the psychotherapist are willing to go with the patient into the depths of his experience. By their respective methods both help him achieve insight adequate for healing. The clinically-trained pastor will not attempt to deal with problems that require medical or depth-psychology training, but he will be glad to confer with other staff members on such problems. He is prepared to understand and deal with the problems which have their root in the patient's "spiritual" or "religious" functioning. The chaplain will work helpfully in matters of guilt, morals, values, religious experiences and concepts (especially compulsive, evasive or immature ones), church relationships, "philosophy of life" (including the meaning of life and death), and life after death. All of these concerns affect, and are affected by, one's relationship with God. The chaplain is willing to enter, so far as time and his specialized training permit, into pastoral counselling with patients to help them come to this healthy condition. The result, for the patient, may vary from an experience of gentle growth to a shaking experience like that of Saul of Tarsus, which Jesus called a "new birth."

Fourth, *incidental services*. Chaplains are sometimes involved in other activities in the psychiatric hospital, such as helping with the hospital paper, social events, or personal kindnesses to patients or their families. These are done as they would be by a personal friend and within the rules of hospital procedure.

The Needs of the Patients

Patients in a large mental hospital have many different diagnoses — from mental retardation, acute and chronic psychoses, personality disorders and neurotic disturbances, epileptic seizures, old age, homelessness, to alcoholism. But all of them have *common needs*, such as friendship, support, acceptance, counselling, forgiveness and worship. Many patients will not be aware that they have such needs, but discover them during their stay in hospital and ask for help. Those who find the most help usually do so in the process of a relationship with one or more individuals. Sometimes, it is the chaplain who may lead them to a healthy relationship with God.

Most patients do not spend nearly so long in psychiatric hospitals as they did in former days. This has led to a change in the pattern of the chaplain's ministry. His concern used to be the creation of a sense of community within the hospital, helping patients out of their isolation into participating citizenship in this community. He depended largely on the chapel services. We still seek this result for long-term patients. A much more urgent need presents itself for the many who are in hospital for a very short period, who go home almost every week-end, and are thus not in Chapel very often, if at all. Our ministry to this increasingly large percentage of patients, must depend more on individual contact. We also have some responsibility for helping their "home" pastors and churches to receive them back into the community in an accepting and helpful way. I sometimes sound out a patient's desire to have contact with his home church or pastor. This may enable him to tell of some problem in that area of his life, or of his concern with the reception he will receive when he goes back home.

How Nurses Can Help

Nurses can often be the best chaplains patients ever have! How? By indoctrinating patients in the nurse's own religion? God forbid! Proselytism in a hospital, even if it were to the faith-group of the chaplain involved, would not be condoned by him or the hospital! Nurses help the chaplain when they:

1. Know something of the chaplain's work;
2. treat the patients as people, not as animals or criminals;
3. respect their right to their religious views and experience, although these may seem "crazy" or are opposed to their own;
4. are sensitive to their spiritual needs, and mention anything that might be significant, to the doctor and the chaplain;
5. encourage them to talk over with the chaplain of their faith-group any problems which they mention which come under the special competency of the chaplain;
6. encourage and assist them to attend and take part in the religious services provided for their faith-group;
7. treat the chaplain as a friend (to the nurse, as well as to the patients) and professional colleague; ask him specifically what he wishes or needs — to see a patient in a place of quiet, to have the nurse accompany him to meet and speak briefly with several new patients, to have a table for a private communion service, and other such requests;
8. are reverent and self-controlled; blasphemy is a sign of lost control, and is destructive in human relationships;
9. invite the chaplains to the nursing staff conference periodically for discussion of mutual concerns.

The good nurse or psychiatric aide assists the patient by establishing a healthy *human* relationship that helps the person come to a wholesome relationship with *God*. The chaplain seeks to achieve this same end. He has a representative "office" and uses religious symbols, but he isn't with the patient nearly as much as the nurse.

Together we can build healthy human relationships with those entrusted to our care so that they may come to a healthy relationship with God and the salvation of their souls.

Half the failures in life arise from pulling in one's horse as he is leaping.
— J. & A. Hare

Conversation is like a boat — if everybody crowds on the same side, it sinks. It needs balance to keep afloat. — Marjorie Pither

The Catholic Chaplain

KEVIN BARRY

The priest has always been a familiar figure at the bedside of the sick and of the dying.

WHILE HOSPITAL care has expanded, due to increased benefits and facilities, the near-silent drama of the Catholic priest in the hospital has remained the same. His role is much as it always was. Whether he resides in a Catholic hospital or visits a public institution frequently, he is today what he was years ago — a sacred minister of the sacraments, a physician, not of the body but of the soul. He comes to foster the spiritual welfare of his sick children. His very office requires him to help them with great care and deep charity, especially those near death.

When we hear the word hospital, we immediately think of the bodily care of the sick. All members of the staff from the administrator down to the humblest employee are concerned, directly or indirectly, with the physical needs of the patient. Since the chaplain does not have a function at the physical level, but rather on the level of things spiritual, his position is often misunderstood if, indeed, it is recognized at all. The chaplain, however, realizes that his function, when recognized, is only one element in a complicated process known as the hospital system. He must try to afford spiritual care in a way that does not unduly disrupt the physical attention. Nevertheless, he wishes to feel free to paddle his own canoe, always mindful of the other traffic in the hospital stream.

Since every one connected with hospital work has the good of the patient as his main aim, it follows that each one will do all he or she can to see that this objective is realized. Some, however, do not know exactly the best way to reach the desired goal as far as the spiritual needs of Catholic patients are concerned. Nurses are not always aware of the ways in which they could assist the chaplain. This brief article may help, in some small way, to show the chaplain's role and his needs in respect to Catholic patients, especially in that area of his function that deals with the sacraments. Naturally, these remarks are not in the least possible way intended to serve the cause of bigotry or controversy. Also, they are not meant to cast any shadow on the hospital with which the writer is connected, or upon the nurses with whom he has worked. These suggestions have been set down after speaking with the chaplains and the personnel of other hospitals.

Although different devices have been invented and ideas proposed in order to realize the great potentialities in the chaplain's function, there is none to compare with the nurse. Irrespective of her religious belief, the nurse is in a favored position to offer help to the Catholic chaplain. She is in close if not constant contact with the patients. That alone would recommend her to the chaplain who wants to know when a patient's illness becomes critical; when the patient will be most receptive to a visit; what the state of mind of the patient is; what the attitude of the patient or his family is. If that co-operation exists, the chaplain has a broad path of approach to the patient.

If the nurse and the chaplain co-operate in the interest of each patient, the chaplain can seem to be everywhere and yet be only where he is most needed. This is especially true in the large hospital where one chaplain must keep contact with hundreds of patients. In these circumstances, as well as in a small village hospital, the nurse can be the eyes and ears of the chaplain. In emergencies, she can sometimes do what the chaplain would do had he arrived in time.

Even more important, the nurse who is eager to promote the entire good of the Catholic patient, will assist the chaplain in whatever way she can when he comes to administer the sacraments. May I explain what the Catholic believes the sacraments to be. They are the spiritual channels through which the grace of Christ flows to His people on earth. Thus it should be evident that, to the Catholic patient, the sacraments of the sick — the opportunity for confession and Communion, or even the personal blessing of the Catholic priest — have great importance. Regardless of what the religious belief of the nurse may be, she should look upon spiritual matters from the patient's viewpoint and do all that she can to see that the visit of the chaplain will allow the patient to draw all possible comfort from it.

Through no fault of their own, many non-Catholics do not grasp the importance of these visits to the patient. They have no idea, sometimes, of what they can do to help. There are certain routine matters. The nurse should know where to find the chaplain and the chaplain should be able to find the patient. If the chaplain is to reach those of his faith, he must first of all know *who* they are and *where* they are. To make a list of patients available at all times to the chaplain may not lie among the duties of the nurse but, in those institutions where this is the case, such a list is not only helpful but, of course, greatly appreciated.

The chaplain's calls to the hospital are not all alike. He may be summoned in an emergency; he may be called before an operation; he may come to make a routine round of visits. If he takes it upon himself to come to administer the sacraments, then he should inform the nurse beforehand about when he is coming and what he would like prepared. (Sometimes a list of what is needed is displayed on each floor). When he has been called by the hospital, whether for an emergency or before an operation, the chaplain does not want to waste time looking for the patients. In large hospitals this would be impossible. Even in smaller institutions, it seems only professional courtesy to conduct the chaplain to the bed of the patient. This would not have to apply to regular visiting times, when the chaplain may wish to make his own way. However, if a room is not checked beforehand, the chaplain may come upon the patient when he or she is not prepared to receive him, causing much embarrassment to both. Catholic patients look upon the chaplain as a spiritual father. They do not want to be the cause of any embarrassment to him or to themselves in his eyes.

Relative to the more immediate preparations that the nurse could make, there are many pamphlets and reference cards available. Catholic nurses would be happy to instruct those not of their faith in these matters. Briefly, these preparations are:

a. In the case of the patient receiving Holy Communion — a clean towel covering the bedside table, a glass of water and a spoon.

b. When the patient is critically ill, the chaplain will administer the sacrament of Extreme Unction, commonly called the Last Rites. Since this involves anointing with oils, the chaplain needs absorbent cotton with which to wipe away the oil. The agents of sin — eyes, ears, nostrils, lips, hands and feet — are anointed. In the case of the latter two senses, these could be made more easily accessible to the priest.

c. In the case of infant baptism, he will need details to record in his parish files. The following are required: infant's name, father's name, maiden name of mother, dates of birth and baptism, sponsor's name. Often the chaplain may not arrive in time to baptize the infant. If this should be the case the child should be baptized by the nurse. This is done in the following manner: Pour water on the head of the child so that the water touches the skin. All grease or creams should be wiped away beforehand. While pouring the water say: "I baptize thee in the Name of the Father and of the Son and of the Holy Ghost."

There may be some nurses who do not seem inclined to give aid to the Catholic chaplain. Sometimes this is due to inconveniences, sometimes to other reasons. The results that can be derived from nurse-chaplain teamwork make it eminently worthwhile to resolve differences in opinion and to accept sacrifices of convenience that may be on both sides. This teamwork, regardless of what the belief of the nurse or the chaplain may be, denotes mutual charity and forbearance, the running ahead of one before the other in thoughtfulness and honor. It will have as its goal, the well-being, spiritual and physical, of the needy person in whom they are both so interested — the patient. All of these things mean better care for patients, and greater success for the entire hospital team.

Jewish Patients in Hospital

David Spiro

The Jewish faith contains rituals of great significance to its believers.

THE JEWISH people have been practising circumcision since the days of Abraham. In Hebrew, it is call *Birth Millah* and is performed on the eighth day after birth. It is considered to be of such great importance that it cannot be postponed, even if the day of circumcision falls on the Sabbath or the Day of Atonement. The operation consists of three parts: *Millah,* circumcision; *Periah,* the uncovering of the organ; and *Mezizah,* dressing of the wound. At the conclusion of the operation, the child is named.

If the infant is losing weight or if there are any indications that the child should not undergo the operation then, upon the advice of a doctor, the operation *must* be postponed. It is not permissible to perform the circumcision until the child has returned to his normal physical condition.

In hospitals where there is only the occasional Jewish circumcision, it might be well to obtain a list of the various articles that are required. In these cases, the Rabbi or Mohel (one who performs the ritual circumcision) is usually invited from a neighboring city to perform the operation. It would make it much more convenient if a tray were in readiness.

When a female baby is born, it is customary to name the child during the Sabbath services. There are many Jewish mothers who are reluctant to give the intended name to the nurse for registration, before the ceremony has taken place in the synagogue.

It would take many pages to attempt to describe the dietary laws even briefly. There are two facts that can be remembered very easily. There are certain foods that Jewish people may eat if they have been properly prepared. There are certain foods that they are not permitted to eat, regardless of preparation. Biblical law forbids a member of the Jewish faith to eat any part of the pig. The only complaint that I have ever heard from any of the patients I visit is that they have asked repeatedly not to be served ham or bacon, but there are many times when these foods are still served, regardless of their request.

When a Jewish person asks not to be served certain foods, it would be well to take extra precautions to see that this wish is carried out. It is not a whim but is grounded in strong religious convictions. One might think that the person could remove this food and eat the remainder, but usually there is a complete loss of appetite. There are also many Jewish patients who will not take milk (or anything made from milk products) together with meat. This has been practised since early childhood. Some patients would rather go hungry than mix these foods. There are other patients who will refuse to eat meat or fowl because these foods have not undergone ritual preparation and are not kosher. During the week of Passover, Jewish patients might be even more particular and refuse to eat any food that contains leaven, e.g. bread, crackers. Arrangements could easily be made with any Rabbi to have special Passover Matzos (bread) brought into the hospital. At the same time the Rabbi could possibly be helpful in explaining what foods might be served during this time.

The Canadian Federation of University Women has announced four fellowships. General criteria for eligibility are: the applicant be a woman who holds a degree from a Canadian university, and whose domicile is in Canada. Specific criteria for each fellowship and application forms may be obtained by writing to the Chairman of the Fellowship Committee: Dr. May Smith, 2424 Crown Crescent, Vancouver 8, B.C.

A Need in our Mental Hospitals

GREGORY MCGILLIVRAY, S.T.L.

Autumn lends itself to reverie, as the golden-brown leaves are gently tugged from the branches by unseen gusts of wind and carried to their final resting place among the others already matting the hardened ground. Like the tumbling leaves, myriad questions crowd their way into the mind as we pause before the mental hospital, serenely framed in the gold of the remaining leaves.

WHO MADE those trees, standing sentinel so elegantly on the hospital grounds? Who made their leaves, so perfect and so unique? Why is this one red and that one brown? Who decided when they should fall, and which one here and which one there? Marvelous and mysterious are the ways of God, and all for a purpose . . . "The hairs of your head are counted . . ."

Interrupting this reverie on the hospital grounds, one can not help but apply these very questions to the people in the scene before us — that group of patients huddled by the hospital wall, or those over there on the bench, or this one scurrying about trying to catch the falling leaves; or even those people on the outside, strolling past on the sidewalk, or casting curious glances as they drive by in their cars; or ourselves, standing appraising the whole diversified scene.

Why should those on the hospital grounds be ill and those passing by be apparently in good health? Why are some free to stroll past as unconcerned onlookers while others are the objects of their curiosity?

In the famous Greek classic *Oedipus* the pagan author puts these words into the mouth of one of the characters as he views a similar scene and throws his hands up in despair: "For who shall raise a hand to fate or draw a sword to destiny? For the gods are mighty and man is mortal."

In the Scriptures, however, we see quite another and much less pessimistic attitude expressed by our Lord before His crucifixion, when He simply bowed His head and said: "Not as I will, but as Thou wilt." Is this not a Christian answer to many of our questions? The value of our sufferings, difficulties, misfortunes and hardships is not in the troubles as such, but in our proper Christian acceptance of them.

Tell this to patients in the mental hospital? Not in so many words perhaps, but it seems clear that we must help them to live according to this spirit — to accept their lives, as we all must, in the circumstances in which we find them; to use their bodies, for the purpose for which they were given by Almighty God — to work out the salvation of their immortal souls. Every man has been given a certain number of talents. The account that will have to be given to Almighty God will be what he did with what he was given.

Everything that helps these patients to work out their salvation comes directly or indirectly under the work of the hospital chaplain. Whether it be the administration of the Sacraments — the most important — a bit of advice, a suggested solution to a problem, a word of encouragement, writing a letter, a willing ear to troubles, a friendly handshake, a warm greeting — all these things done in God's name are valuable, both to the patient and to the chaplain. "As long as you did it for one of these, the least of My brethren . . ." A kind smile, a soft word and a peaceful manner are certainly appreciated by the patient and are very helpful in gaining the confidence of the more nervous ones. In most cases, the latter is an absolute necessity, which sometimes makes the chaplain useful to the hospital staff as a liaison officer. In a word, the aim of a chaplain is the salvation of those souls committed to his care according to the most normal means permitted by the condition of the patient, the regulations and operation of the hospital, and the demands of time. Naturally, the needs of a patient vary according to the type and degree of his illness, but one common need is for human understanding. This is something that everyone, not just a chaplain should try to provide. He is not in nearly so good a position to exercise this understanding among the patients as those who, because of their occupations, are with the patients most of the time. Thus nurses, by their training, ideals and position, can and do exercise many virtues to make the work of the chaplain and the doctors, and the operation of the hospital more pleasant and efficacious.

If I were asked what nurses could do to aid the work of the chaplain, or anyone else, in a mental hospital, I would have to reply: Do what you are doing. Continue to be faithful to the high ideals of your profession; continue to live up to the name so often affectionately applied to you — angels of mercy; continue to exemplify those qualities for which the Canadian nurse is so well known — kindness, understanding, respect, patience and goodness; continue to be *Semper Fidelis* to the dedicated goals of your great calling. The chaplain will always feel welcome and at ease when he knows that he has someone working with him on his side, for the spiritual welfare of those less fortunate humans whom God has chosen to place under our humble care. Not only the patients, but all of us will benefit if we are able to keep constantly in our minds the realization that each one of these troubled persons has a soul — just like ours — destined one day for the eternal happiness of heaven.

All of us, regardless of our age, health, wealth, social position or success in our profession, will one day — just as the leaves now being shed from autumn branches — be tugged from our present existence and laid, like the dead foliage, in our final resting place. All equal in the eyes of God, the patients, the curious passers-by, the nurses and the chaplains, we will be called to give an account of our stewardship. Please God, we will have done our respective jobs so that we will hear the welcome words of our Master "Well done, good and faithful servant."

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — December 1921)

Excerpt from an address given by Mabel F. Gray. Why do we need a secondary body (nursing housekeepers) with a less complete training than the nurse? Are the nurses of today too highly trained?

A secondary body is needed because there is a shortage of fully trained nurses, not because there are fewer graduated each year, but because there are so many different kinds of service open to the graduate of today.

Are the nurses of today too highly trained? I should say not, decidedly, no! They cannot be too well trained for the many important tasks awaiting them . . . With the seriously ill patient, it is impossible for any one woman to look after the patient as well as doing everything else. With the patient who is not seriously ill, the nurse of today considers the main duty is housekeeping, with simple nursing care such as might be given by almost any person. Yet not quite by anyone, and certainly not safely by anyone without a certain knowledge of the essentials of nursing. This then is the reason for the secondary, less highly trained body.

Speaking especially to training school superintendents, we must remember that there is a danger of our vision being obstructed by the wall of the institution. There is the danger of thinking that all the sick are within hospital walls, and that if they are not, they should be. There are degrees of illness and it seems only reasonable to suppose that all do not require the same skilled nursing care.

* * *

As a preliminary step toward establishing a standard curriculum for use in the schools for nurses in Canada, a letter was sent to the different provincial associations, asking them to send a copy of the standard curriculum used in their province, if such had been established. Copies were received from British Columbia, Saskatchewan, and Alberta. Apparently in the other provinces, the curriculum followed is decided by each school.

It is thought that nursing education in Canada would be greatly benefited if a standard could be agreed upon, in which would be outlined not only what was desirable to follow, but also the minimum that would be accepted in any school seeking recognition in the national association.

Chaplain in a General Hospital

DONALD V. WALDON, B.SC., B.D.

A chaplain comes to the patients in a capacity that is duplicated by no other member of the hospital staff.

ON ENTERING a general hospital one is immediately conscious of an entirely different and separate world, with its own hierarchy, governing system, economic standards and rules of social behavior. Within its confines, efficiency is the key note of all activity. Human weakness and error are kept at the very minimum — cleanliness and order at the maximum. The tendency at first, is to become so involved in the mechanics of this strange new world that the reason for its existence is forgotten. There are patients in the beds who have entered the institution so that they might find cures for the various disruptions that have beset their physical bodies. Upon these patients the chaplain must fasten his whole attention, for they are his special concern. He represents the Christian Church and is charged with the responsibility of bearing the glad news of the One Who is concerned with and cares for all His creatures.

The Patients

In what state will the chaplain find the patients? What will be the needs of those who are confined to hospital beds? What of their mental and emotional configurations? To most, the hospital routine will be new and confusing — perhaps even terrifying. Pain may dull their senses and increase feelings of insecurity due to new surroundings, unfamiliar practices, strange faces. Days devoid of activity become tedious and wearisome. If operations are to be faced, the question of the doctor's ability to diagnose correctly and to perform accurately is important. Most people try to live independently of others, yet here they are placed completely in the hands of total strangers.

The most important factor in any patient's experience is that drastic change from a world outside that is extremely busy, affording little time for thought and reflection, to a situation in which leisure time is forced upon him. Perhaps, for the first time, he can reflect upon the deeper issues of life and delve into the problems which have hitherto been pushed into the background by full schedules and the rush of daily work.

> If God were good, He would wish to make His creatures perfectly happy, and if God were almighty He would be able to do what He wished. But the creatures are not happy. Therefore God lacks either goodness, or power, or both.[1]

This, very simply stated, is a question in the minds of those who suffer. How will they reconcile this with what they know of God? Some are inclined to ask, "What kind of a God is He to let this happen to me?" When facing severe illness there is a question of survival, death, and life after death. As day follows day, loneliness is sure to have its effect.

There are practical considerations as well. The family must be cared for and a job is waiting. There are funds to be raised for large hospital and doctors' bills. Who is to make all the arrangements for household affairs? What if the confinement period be longer than expected? What is to happen then?

In all fairness it must be stated that not all patients go through such trying thoughts and feelings. Some never reach a time of soul-searching and deep thought. Some never reflect on the great themes of life. Some seem quite oblivious to the situation in which they find themselves. Some have such religious faith that no amount of pain, discouragement or anxiety can shake them. These are considerations which must be taken into account by the chaplain as he works among his patients.

The Chaplain

The chaplain comes to his task with certain qualities of personality that aid him as he makes his rounds. He is, first, an ambassador from beyond the hospital walls. He is a visitor with no connections to the hospital staff. He brings welcome relief to those who see only doctors, nurses, orderlies, and x-ray technicians. He is one who can bring the patient into contact with the outside world once again.

The chaplain comes as one skilled in the art of listening. He must learn how to listen patiently, with sympathy and understanding, to the patient's needs, fears, aspirations, hopes, family affairs and religious beliefs. A good chaplain will not wish to preach and teach. His main concern should be to accept the patient where he is and then, by carefully guiding the conversation, lead him in self-expression. He tries to induce self-understanding. For this task the chaplain's stock-in-trade is an active and open mind, ready at all times to sense deeply-rooted emotions and feelings. Often the best chaplaincy work is done by those who have learned simply *to listen*.

If, through physical distress, the patient's mind has become obsessed with the great problems of life, death, and immortality, then the chaplain stands ready to aid in the search for clearer answers to questions which loom large in the minds of sick persons. They can turn to the chaplain knowing that they will find a ready listener, an understanding friend, a sympathetic counselor. The chaplain must have a calm and sure faith himself which radiates from his personality, not a complete list of pat answers for every problem. Example goes much further than words can ever go.

Patient-Chaplain Relationship

Both patient and chaplain must converse and act as if there were a third Person present in the room. The minister is God's representative and attempts always to lead other to an awareness of and the nearness of His presence. There is a very real danger that the patient will put all his faith and trust in the chaplain, rather than in the One whom he represents. The patient needs a very much higher authority upon whom to rely if fears are to be calmed, doubts are to be banished and unrest of mind and spirit is to be supplanted by peace.

Obviously, there are divergent ramifications of each particular situation which cannot be covered within the confines of an article. Every patient-chaplain encounter has its own peculiar set of circumstances, variety of topics of conversation and is affected by personality traits which must be taken into account in as many different ways.

How the Work is Accomplished

We turn now to the practical side of this issue. When does the chaplain start and how can he be helped to carry out his mission successfully?

He must try always to engender a sense of quietness in the patient. This does not mean simply the absence of noise or confusion. It is a state of mind that can be likened to peace of mind. Quietness comes through patience in the long waits, faith in the medical profession's ability to restore health and trust in the mercy and goodness of God. Quietness is the assurance of God's purpose for mankind through life, sickness or even death. A patient who faces an operation knowing that there is only a slim chance of survival will hardly achieve quietness of mind and soul if he does not understand that pain and death and life are all under the guidance of God and fit into His eternal purposes.

In order that the chaplain may help to bring quietness to the patient, he must first try to see that as much as possible of the busy hospital routine is eliminated during his visits. This condition is easily satisfied in a private room, but on the wards it becomes more difficult. Most hospital wards are equipped with curtains which can be closed by the nurse or attendant, to separate individual patients from the rest of the ward. This being done, the chaplain and the sick can be "alone" with God. Any help which can be given by nurses in providing this privacy is very much appreciated.

Another consideration is the natural hesitancy that most people feel about displaying their deep religious feelings. They tend to feel awkward and embarrassed in the presence of other patients or staff while the chaplain is with them.

Having achieved a certain degree

of seclusion, the chaplain can pursue any course of action or conversation which will lead the patient to put his trust in him. Until confidence has been realized the patient will not reveal his inner feelings or discourse openly concerning private matters. It is not the role of the chaplain to pry into private affairs or to bring to light all the sorry and sordid events of one's life. His presence, as one who listens with intelligence and understanding, provides the opportunity for the patient to speak of those things which are foremost in his thoughts. He may share his problems or his theses with one who can meet him on his own intellectual and emotional level. Hence, the great importance for complete confidence.

The chaplain is always alert to any opportunity to speak as God's representative. He must be convinced that in the Eternal Father and the Son is to be found the only way of life. This conviction he hopes to convey to the distressed and questioning patient. His opportunities arise if the patient asks for prayer, or for scripture readings. Prayers and scripture reading are not simply prayed or read as a matter of course. To do so might easily offend the individual's priority. The chaplain asks and then complies with the wishes of the patient. A chaplain might do far more good by taking an interest in the intricacies of a diesel engine or the problems facing a nine-to-five office worker, than reading a chapter from the Bible.

What can prayer accomplish? It can put an individual in direct contact with his God. It is the means by which communion is held between man and his Creator — the Source of all love, wisdom and power. Prayer implies dependence on Another for strength and help. It leads one away from self-centredness and places emphasis on the highest and the best. It should always be directed to the end that the patient's confidence in God is strengthened. For these reasons it can be a potent force in effectively bringing a sense of quietness, of peace, to the mind of one who is suffering. Once he is assured that he does not face life's trials and problems alone, but can place his faith in Someone who is mightier than he, then relaxation is the result. A sense of well-being can pervade his personal life and fill his mind with hope.

Scripture readings fit into the same general pattern. A certain quality of authority permeates scripture. Perhaps it is the training to which we are subject from our youth which gives scripture its potent force. In religious teaching regarding the Bible emphasis is put upon the fact that between its covers is to be found the Word of God. Through the expressed thought of the Biblical writers God speaks to mankind.

Very few patients do not respond with gratitude to those thrilling words: "I will lift up mine eyes unto the hills, from whence cometh my help. My help cometh from the Lord, which made heaven and earth." The spiritual comfort of the Shepherd psalm is certainly well known. The Word became flesh in Jesus Christ. We see in Him the man tempted and tried, yet not yielding. We find Him as the greatest Healer whose concern for the sick goes beyond what man can accomplish. Through Him are revealed the high purposes of God the Father, for mankind. We accept Him as One who leads us along the way to eternal life and into the presence of our Creator.

Facing death on this earth is never easy and yet much comfort must come from the words of the Master: "I go to prepare a place for you." I am sure that faith in these words has helped many a struggling soul overcome mental anguish and slip into the next life peacefully and even with anticipation.

You who are of the nursing profession or any who are employed in a healing capacity are aware of the fact that to heal means to restore both body and mind to perfect health. If one is restored and the other not then the work is only partially complete. The chaplain finds his task in assisting to achieve complete restoration of the sick. More important is the chaplain's prayer that, whether life or death result, the patient will leave the hospital better equipped to face his Maker.

Reference

1. Quoted in *The Problem of Pain*, C. S. Lewis.

REMOTIVATION TECHNIQUE

JOSEPH E. LEBLANC, R.N.

Remotivation technique is an adjunctive form of treatment that is being used in the nursing care of the mentally ill in hospitals. It originated in the United States four years ago, and has made great strides since.

What is Motivation?

BEFORE DISCUSSING remotivation and the technique used to produce it, mention should be made of movitation — what it means in sickness and how it affects the nursing care of patients. Motivation has been defined as "the process of arousing and sustaining behavior, or of changing the pattern of an activity in progress." It is a drive, a tendency which impels to action, the "why" of behavior.

Most of us in the field of nursing, and especially those in psychiatric nursing, believe and teach that all behavior is meaningful and has motivating forces behind it. For this reason we constantly try to discover the reason why a patient does not eat or sleep, or why he is demanding, aggressive or impulsive, before we decide on an approach to the problem. We also know that when a person becomes ill, there are motivating forces, either of a conscious or an unconscious nature, which precipitate patterns of behavior that are unacceptable or even destructive to society. The nature of this behavior depends upon the type, length and severity of the illness.

Before they became ill, most patients functioned as productive citizens. They did so because they were properly motivated, that is, their biological and social needs were appropriate to the demands of society. During the process of living each of us is exposed to certain stresses and strains from our environment. Some of us are able to resolve the conflicts created by these stresses, others fail. Failure to resolve these conflicts and the resulting inadequate modes of response may be due to poor environment, heredity, and physiological factors.

As people become ill, their contribution to society lessens. The problem is further complicated by the fact that social illness is difficult to understand, and many people attach stigma to it and are prejudiced against those who exhibit it. In addition, efforts to prevent and cure mental illness are severely handicapped by the present, limited body of scientific knowledge. The result is that some patients spend many years, sometimes the rest of their lives, in hospital.

Regardless of how withdrawn, depressed, or regressed a patient becomes, we know that at one time he was motivated in his own way and guided by his personality and life experiences to be a member of a community. Because of his illness, his personality has become so wounded that he can no longer function and may have to be hospitalized. Part of his personality may function at a primitive level, while the rest remains intact. The part that is still intact can be remotivated. The hope is that by strengthening this portion, the wounded part will be favorably affected, resulting in a more amenable patient with whom the psychiatrist may work.

What is Remotivation?

Remotivation may be defined as "moving again." Remotivation technique is one tool that the therapist can use to help patients, and bring them closer to other therapies, such as occupational, recreational, industrial and individual and group psychotherapy. It may be described as a simple form of group therapy that is objective in nature. It is carried out by the ward attendant with his own patients in their setting.

What is the Technique?

One to twelve patients who might benefit from the treatment are selected by the doctor, the head nurse and the remotivator. A series of 12 meetings, lasting 45 to 60 minutes each, are conducted with this group of patients once or twice a week. The patients sit in a circle and the attendant stands in the centre.

A topic is selected for discussion and the attendant follows five steps which give the meeting its true structure of continuity.

Step 1 — *Creation of a climate of acceptance.*

First the attendant makes sure that everyone knows each other. He then greets them individually, making short comments to each about his appearance, progress or ward life. This gives patients a feeling of belonging to this particular group.

Step 2 — *Bridge to the real world*

The attendant spends 10 minutes or so trying to get the group to touch on a desired topic, by asking direct, easy-to-answer questions. At first, this is done in a general, broad way, so as to bring the discussion gradually to specific questions that would lead to the topic he has in mind. When this is accomplished, the group reads a poem related to the topic. This, along with props and visual aids, is what really forms the bridge to the real world. The patients now have something real and objective to talk about.

Step 3 — *The world we live in*

The attendant and the patients spend 15 to 20 minutes exploring the topic thoroughly, again using visual aids and their own experiences. This usually creates a situation bustling with interaction and enthusiasm which, as a rule, is not observed many other times during the patient's day. If an inability to communicate is a cause or a result of mental illness, then these remotivation meetings should be of great therapeutic value.

Step 4 — *Sharing the work of the world*

The group discusses all the work activities connected with the topic. A by-product of this step is the discovery of certain occupational interests, which, if followed up, may assist in the rehabilitation of the patients.

Step 5 — *Climate of appreciation*

The attendant spends a few minutes thanking each patient for attending the meeting and invites them all to come to the next one, which gives them a feeling that this is something that they share.

History of Remotivation Technique

The late Mrs. Dorothy Hoskins Smith, a volunteer in a Veterans Administration Psychiatric Hospital in the United States initiated the technique by using reading as a social activity. She found that she could arouse the patients to think about real things, and noted certain reactions that indicated that they liked this method of communicating with each other.

From this idea, Mrs. Smith structured the technique as we know it now. Community groups, the Mental Health Association of Southeastern Pennsylvania and the Mental Health Education Unit of Smith, Kline and French Laboratories supported the program. It was through their efforts that remotivation technique began at the Philadelphia State Hospital in the summer of 1956.

Mrs. Smith trained 200 nurses and attendants during her short time there, but due to her untimely death, the teaching program stopped. A team comprised of the hospital's nursing personnel took over and taught the technique in hospitals across the country. Some hospitals now have enough data to conduct their own research projects regarding the program.

A few Canadians have attended the Smith, Kline and French Laboratories' remotivation technique training courses in the United States and are now training other Canadians to carry out the technique here.

Some hospitals have modified the technique and called it by another name, but the basic principles of the treatment which are fundamental to good psychiatric nursing care are still retained.

The Values of Remotivation

Many of the values were predicted by the organizers, while others have been observed since, and serve as good goals for the remotivator. They can be divided as follows:

1. *To the patient:*

   a. It takes him out of the drabness and stereotyped routine of ward life.

   b. It remotivates the part of his personality that is still intact.

   c. It provides something objective in which he can become interested.

   d. It gives him something to talk and think about before, during and after the meeting.

   e. It gives him an opportunity to value himself and gain self-esteem.

f. It makes him part of a group.

2. *To the remotivator:*

a. It gives him an opportunity to do more than give plain, custodial care.

b. It enables him to know his patients much better and increases his interest in them.

c. It makes him aware of his patients' peculiarities; this information is very valuable to the doctor.

d. It gives him an opportunity to do something really worthwhile with his patients; something he can call his own.

e. It gives him a feeling of belonging to the psychiatric team.

3. *To the doctor:*

a. It may provide the groundwork for other therapy.

b. It gives him an opportunity to evaluate his patients.

c. It may provide him with information regarding the patients' work interests or tendencies that could be valuable in rehabilitation.

Administration of the Program

The program is under the direction of the nursing division. The director of nursing appoints a coordinator who is responsible for the functioning of the program. This person may or may not do the teaching, but it should be a nurse who is well-oriented to the technique and has an optimistic attitude toward it. As the program grows this can easily become a full-time job, even with the assistance of a few counsellors who are selected from the group of remotivators to help supervise the activities of the program.

A Remotivation Council should be formed as soon as the program begins, and should include representatives from each of the professional disciplines. It should meet once a month and have policy-making and support-giving as its chief functions.

The importance of having a remotivation library available for the remotivators' use cannot be over-emphasized. It provides a central place for visual aids, displays, and files and also a quiet atmosphere where the attendant can prepare his material.

Other Disciplines Can Help

In a number of institutions, psychological tests are used as an aid in evaluating the patient's status along certain defined dimensions, both before and after a remotivation series. A rating scale can be used and/or a series of performance tests that have definable behavioral correlates. Such a tool serves to provide an independent and quantitative measure or estimate of change in the patient which adds to the clinical impressions. Further, it serves as a means of getting more active participation from other departments and a concrete display of interest in the remotivator's work. It may highlight the specific behavioral characteristics being affected by the remotivation program, thus giving an increased understanding of what is occurring in the remotivation process. It may also point out the areas in which more emphasis needs to be placed, thus giving direction to the content of the program.

Summary

A few comments in support of the program, although it has been in progress for less than a year in this hospital, are not premature. In order for it to be successful the following considerations must be accepted.

1. Maximum support from the hospital administration.

2. Proper orientation to the program for all departments of the hospital.

3. Any new method of treatment is threatening to some members of the staff and will be met by resistance; in time this will subside.

4. An enthusiastic council whose functions will differ, depending on each hospital's needs, must be operating.

5. The coordinator must be interested and it must be considered a full-time job as the program becomes hospital-wide.

6. There must be follow-up treatment of some kind for the patient, so as to give the attendant a feeling of accomplishment.

7. There must be a separate, comprehensive library for the remotivators' use.

8. Training in remotivation technique may or may not be compulsory for the attendants as a form of in-service education, but it should be performed on a voluntary basis only.

9. The attendants must be given time, during their on-duty hours, to prepare their material.

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About Books

The Maternity Cycle by Margaret G. McPhedran, R.N., M.A. 158 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 1961. Price $2.35.

This is a Canadian publication by a Canadian author. Her aim is "to present a concise description of the physiological processes which are involved in the reproduction of the human species and to present it in a way which will make it useful to nurses." The material has been prepared for both a graduate and student nurse readership.

The author notes that certain areas have been referred to very briefly or omitted entirely. Psychological adjustments of the mother and possible complications involving either the mother or baby have been given only brief mention at appropriate points. Nursing measures have not been included since such information is readily available.

"It is the belief of the author that the care provided by a nurse at any point in the maternity cycle should be of a highly individual nature and that it should be planned in direct relationship to the particular needs of each mother and her infant." The emphasis is on the normalcy of the maternity cycle. The entire process of child-bearing is examined in this light. The author's hope is that with very broad knowledge of this normal human function, the nurse will be helped to give the individualized care that she considers so essential.

A History of the Nursing Profession in Great Britain by Brian Abel-Smith, Ph.D. 290 pages. Springer Publishing Company, Inc., 44 East 23rd St., New York 10, N.Y. 1961. Price $5.75.

Reviewed by Joanne Walsh, Nursing Instructor, Hôtel Dieu Hospital, Chatham, N.B.

It was refreshing to obtain the structure of the nursing profession from such an objective viewpoint. In contrast to several other books of this nature which are usually quite detailed concerning the personal lives of the individual people involved, this text gives a more concise history of the profession. The author attained his objective through a chronological study of the structure of the nursing profession.

This is a good book for anyone wanting to know the early beginnings of the nursing profession in Great Britain.

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Other Publications

Control of Malnutrition in Man. Prepared by the Subcommittee on Control of Nutritional Diseases. 140 pages. American Public Health Association Inc., 1790 Broadway, New York. 1960. (Released 1961). Price $1.50.

This is "a concise presentation of current knowledge about the practical control of human malnutrition." The American Public Health Association recognizes the significance of nutritional diseases in our modern world through the publication of this manual. High economic levels and high living standards do not necessarily prevent nutritional diseases. "Lack of dietary information, misinformation, fads and food taboos can and do produce malnutrition in the midst of wealth and plenty."

The text presents information on protein and caloric malnutrition, vitamin and mineral deficiencies and a variety of conditions linked with nutrition such as anemias, food allergies, celiac disease, phenylketonuria.

From Girlhood to Womanhood by Albert Sharman, M.D., D.Sc., F.R.C.O.G. Foreword by Lady Isobel Barnett, M.B., Ch.B. 72 pages. The Macmillan Company of Canada Limited, 70 Bond St., Toronto. 1960. (Released 1961). Price $1.00.

This little book giving sexual information has been written with the needs of the adolescent girl in mind. The author comments that "Things My Mother Never Taught Me" had been suggested as an appropriate title. Many mothers are extremely shy about discussing female bodily function with their daughters. "If a girl can know and understand the changes she is undergoing as she grows up, then she stands a better chance of developing into a healthy, happy, and confident young woman."

The author discusses the female organs of reproduction; puberty; menstruation and complications; vaginal discharges; marriage and child-bearing.

Maternity Nursing. A Textbook for Practical Nurses. By Inge J. Bleier, R.N., B.S. 159 pages. McAinsh and Company Limited 1251 Yonge Street, Toronto 7. 1961. Price $2.75.

The place of the nursing assistant on the obstetrical nursing team is recognized in this text. It contains a simplified account of pregnancy and childbirth with emphasis on normal obstetrics. Complications in labor and possible abnormalities and diseases of the newborn are presented. There is a glossary of obstetrical terms appended, as well as a series of test questions.

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General Duty Nurses. Starting Salary: $297 for Registered, $282 for Non-Registered with yearly increments. 4-wk. vacation, all statutory holidays with pay. Group medical insurance, superannuation plan. Nurses' home available. Apply: Director of Nurses, Nicola Valley General Hospital, Merritt, British Columbia.

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Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $350 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

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Operating Room Nurses for modern 200-bed General Hospital along the shores of Lake Michigan, 30-min. from Chicago. Progressive salaries and policies. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago, 6-room brand new operating suite, utilizing most current "nurse saving" methods & equipment. If you're a confirmed OR nurse you'll be right at home in our OR! If you feel you might be interested in OR (but aren't sure) **our** OR will convert you, beyond doubt. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

COURSES FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: O.R. NURSING OPD. NURSING, MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graddates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

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Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks vacation. In-Staff Education program well established during winter months.

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with consideration for experience or special preparation.

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MONTREAL QUE.

NURSING OPPORTUNITIES

In this modern 400-bed non-sectarian hospital in Administration, Teaching, Staff Nursing.
- Certified Nursing Assistants also required.
- Openings in all Clinical Services • Excellent personnel policies • Bursaries for post-basic courses in Teaching and Administration.

For further information, please write:
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REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS
required by
TORONTO EAST GENERAL HOSPITAL

Residential Area. Good salaries and personnel policies. 40-hour week — differential for afternoon and night duty. Pension Plan.

Apply to:

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TORONTO 6, ONTARIO.

DIRECTOR OF NURSING

For modern General Hospital, expanding to 50-beds, 12 bassinets, completion in 1961. Residence accommodation available.

Salary commensurate with experience and qualifications.

Apply giving full particulars of training and experience to:

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Immediate openings for

ASSISTANT DIRECTOR OF NURSING • REGISTERED NURSES

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THE DIRECTOR OF NURSING, NORTH BAY CIVIC HOSPITAL, NORTH BAY, ONTARIO.

Staff Nurses 380 bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment. " Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks, annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks. 5 yrs — 4 wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply:' Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

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General Duty & O.R. Nurses for 210-bed General Hospital, start—days $355-$395, evenings $380-$420, nights $375-$415. O.R. starts $385. University city, postgraduate study at 2 universities, 40-hr. wk., 7 holidays, vacation, sick leave benefits, free Blue Cross hospital-medical insurance & $1,000 life insurance. Retirement program, extensive Intern-Resident educational program, living quarters available. Write: Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington. 'Come to the Seattle World's Fair April 21 - October 21, 1962.

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Registered Nurses (2) immediately. Salaries as per SRNA schedule, with increments & benefits, 40-hr. wk., fully modern nurses' residence on hospital grounds, daily bus service to the city. Recreational opportunities. Apply to: Fred Howlett, Secretary, Union Hospital, Mossbank, Saskatchewan.

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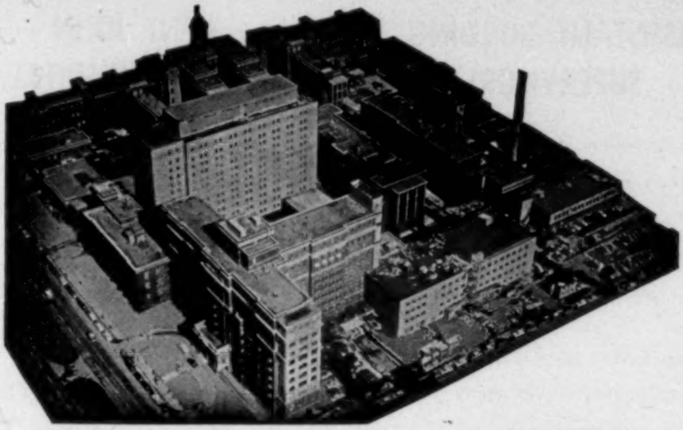

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for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units
Rewarding Experience — Excellent Personnel Policies

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in modern 20-bed hospital located in thriving Northwestern Ontario community. Starting salary $275 minimum to $325 maximum for three years' experience. Board and room in modern nurses' residence is supplied at no charge. Excellent employee benefits and recreational facilities available. Further particulars on request.

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Apply:

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These challenging positions at the senior administration level are located in separate 500 and 600-bed units. Experienced nurses with university preparation are desired.

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VANCOUVER 9, B.C.

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Saint John, N.B.

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SUPERVISOR

for

Pediatric Division

74-beds

A CLINICAL INSTRUCTOR

is responsible for

Student Program

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Director of Nursing

NURSING SECRETARY

needed by

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EXECUTIVE SECRETARY, RNANS
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Requires the Services of a

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for the hospitals of Nova Scotia which participate in the Provincial Hospital Insurance Plan.

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To assess all phases of nursing service (including specialized Departments) and education in hospitals; to make recommendations for solving problems and improving quality of service; to carry out studies and research projects in the field of nursing as required from time to time; to act as advisor to the Commission and its staff in all matters related to nursing.

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Application Forms may be obtained from the

NOVA SCOTIA CIVIL SERVICE COMMISSION,
P.O. BOX 943, PROVINCIAL ADMINISTRATION
BUILDING, HALIFAX, NOVA SCOTIA.

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REQUIRES

Administrative Supervisor for Operating Room
Instructor in Surgical Nursing
Instructor in Medical Nursing

For further information write:
THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

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And

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Required for a new 220 bed addition, in Pediatric, Surgical, Medical and Obstetric departments. Duties to commence early in 1962.

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vacancy for

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at
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Will afford job opportunities
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and
CERTIFIED NURSING ASSISTANTS

Beautifully located on
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Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

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For further information write to:

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Salary - $300 to $320 per month 40 hour week, no split shifts.

Vacation - 18 days plus 10 statutory holidays a year, 21 days sick leave cumulative from time of employment.

Transportation will be advanced if necessary.

Apply: Matron,

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BERWYN, ALBERTA.

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For active General Hospital (50-beds) with full complement of services. Building completed February 1961. Operating Room supervision experience essential. Salary commensurate with qualifications and experience.

Apply giving full particulars of training etc.

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111-bed modern hospital in
thriving community on
Vancouver Island.

Apply with record of experience, training and references to:

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Applications are invited
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ASSISTANT DIRECTOR OF NURSING SERVICE

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Position will be open on
April 1, 1962. Salary commensurate
with qualifications and
experience.

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DIRECTOR OF NURSING

FOR

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SQUAMISH, B.C.

For full particulars apply:
Administrator, stating
qualifications and experience.

SQUAMISH GENERAL HOSPITAL,
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For modern 103-bed General Hospital opened in 1959 in metropolitan area of Vancouver. Please apply first by letter giving full details of training, experience, qualifications and salary requirements to:—

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now in construction of a new 220-bed modern hospital

Requires:

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MEDICAL CLINICAL INSTRUCTOR

with postgraduate preparation — duties to commence August 1961.

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Are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

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AND

CERTIFIED NURSING ASSISTANTS

for 60-bed General Hospital in Northern Ontario - Gross salary for nurses registered in Ontario $310 monthly - Certified Nursing Assistants $210.

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Experienced with postgraduate training, for 140-bed new hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

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ROSS MEMORIAL HOSPITAL,
LINDSAY, ONTARIO.

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requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL } DEPARTMENTS
SURGICAL } DEPARTMENTS
OBSTETRICAL } DEPARTMENTS
& PSYCHIATRIC } DEPARTMENTS

Apply

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ASSISTANT DIRECTOR AND
ADMINISTRATOR OF THE DEPARTMENT
OF NURSING.

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

for salary rates & personnel policies
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requires

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(2) **General Staff Nurses** for medical, nursery and postpartum areas.

Apply to: **ELLEN C. McLEAN,**
DIRECTOR OF NURSING.

DIRECTOR OF NURSING

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Further your Nursing Experience

Opportunities open for
GRADUATE NURSES
in all areas

Liberal personnel policies
Hospital within walking distance of
Wayne State University

Every effort is made to provide the opportunity for each nurse to reach her potential

Must be eligible for registration in the State of Michigan

Write:

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(5) Program for Registered Nurses leading to Bachelor of Science in Nursing Degree

(6) Program of two Academic years leading to Master's degree in Nursing Administration.

For further information apply to:

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Both of these courses lead to the B.S.N. degree. Graduates are prepared for public health as well as hospital nursing positions.

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b. Diploma Courses, one year.
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KINGSTON, ONTARIO

UNIVERSITY OF SASKATCHEWAN
SCHOOL OF NURSING
in cooperation with
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McGILL UNIVERSITY

GRADUATE COURSE
in
NEUROLOGICAL AND NEUROSURGICAL NURSING AND OPERATING ROOM TECHNIQUE

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- GENERAL MEDICINE
- GENERAL SURGERY
- OPERATING ROOM
- OBSTETRICS

Classes: March and September
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Substantial remuneration
Meals and Laundry provided.
Ability to speak French essential.

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- Full maintenance and a stipend of $237 per month for the first three months, $247 per month for the last three months, plus maintenance.
- REGISTRATION FEE IS $20
- Course starts **September 16th & March 16th.** Ophthalmic Nurses in great demand for hospital eye departments, operating rooms & ophthalmologists' offices.

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Director of Nurses,
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SCHOOL OF NURSING

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   Classes—September and February.
   (b) Two month clinical course in Gynecological Nursing.
   Classes following the six month course in Obstetrical Nursing.
   (c) Eight week course in Care of the Premature Infant.

2. Six month course in Operating Room Technique and Management.
   Classes—September and March.

3. Six month course in Theory and Practice in Psychiatric Nursing.
   Classes—September and March.

For information and details of the courses, apply to:—

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A Four-Year Course *which* prepares students for all branches of community and hospital nursing practice and leads to the degree, Bachelor of Science in Nursing (B.Sc.N.) It includes studies in the humanities, basic sciences and nursing. Bursaries, loans and scholarships are available.

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School of Nursing,
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2. Demonstrations and Clinics.
3. Experience in Thoracic Operating Room and Postoperative Unit.
4. Full maintenance, salary & all staff privileges.

For information apply to:

DIRECTOR OF NURSING, NOVA SCOTIA SANATORIUM, KENTVILLE, N.S.

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Offers to Graduate Nurses a six-month post-basic course in Psychiatric Nursing. Courses commence in September and February. Maintenance and remuneration provided.

EMPLOYMENT OPPORTUNITIES

General Duty Nurses required. Preference given to nurses with experience in Psychiatric Nursing. Good personnel policies. 40-hour work week. Minimum gross monthly salary — $290.

This is an active treatment Mental Hospital offering several courses in nursing:

(1) An approved course in General and Psychiatric Nursing.
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(3) Affiliation in Psychiatric Nursing for Student Nurses.
(4) Post-basic Course in Psychiatric Nursing.

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PONOKA, ALBERTA.

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For complete information write to:

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4 months special Eye, Ear, Nose & Throat Nursing

Approved Students enter under Visitors Exchange

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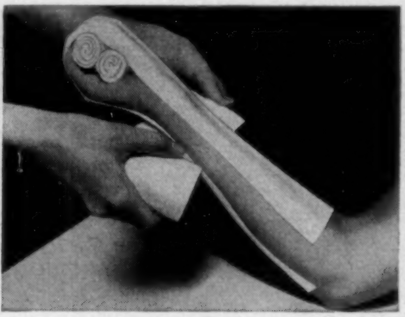

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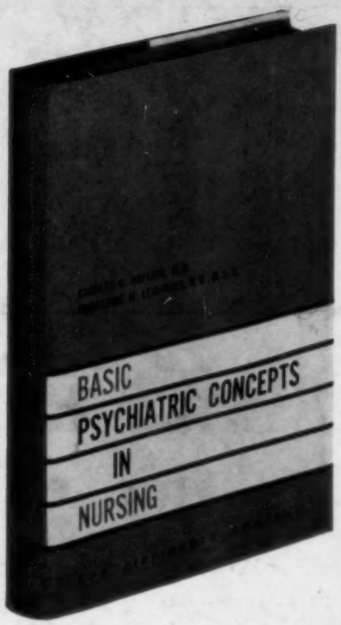

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